TABLE OF CONTENTS

M01 MEDICAID APPLICATION

SUBCHAPTER Page

CHAPTER M01
MEDICAID APPLICATION
SUBCHAPTER 10

GENERAL INFORMATION

TABLE OF CONTENTS

M01 MEDICAID APPLICATION

M0110.000 General Information

M0110 General Information

M0110.100 Legal Base and Agency Responsibilities

A. Introduction

Medicaid is an assistance program that pays medical service providers for medical services rendered to eligible individuals. The Medicaid eligibility determination consists of an evaluation of an individual's situation that compares each of the individual's circumstances to an established standard. Requests for Virginia Medicaid must be made in written form on an official Medicaid application or in the Application/Benefit Delivery Automation Project (ADAPT) system.

All activity of the agency in receiving and acting upon an application must be consistent with the objectives of the Medicaid program and be conducted in a manner which respects the personal dignity and privacy of the individual.

B. Legal Base

The Medical Assistance Program (Medicaid) is established under Title XIX of the Federal Social Security Act and is financed by state and federal funds. The State Plan for Medical Assistance (State Plan) is the official body of regulations covering the operation of the Medicaid program in Virginia.

Virginia law provides that the Medicaid program be administered by the Department of Medical Assistance Services (DMAS). Determination of eligibility for medical assistance is the responsibility of local departments of social services under the supervision of the Department of Social Services (DSS).

Exception: DSS carries direct responsibility for the determination of eligibility of certain patients in Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) facilities and for their enrollment in the Medicaid program.

C. Agency Responsibilities

1. DMAS

The administrative responsibilities of DMAS are:

- the development of the State Plan to cover eligibility criteria and scope of services, in conformity with federal law and regulation,
- the determination of medical care covered under the State Plan,
- the handling of appeals related to medical assistance,

- the approval of providers authorized to provide medical care and receive payments under Medicaid,
- the processing of claims and making payments to medical providers, and
- the recovery of Medicaid expenditures in appropriate cases. Suspected applicant fraud is a combined responsibility of both DMAS and DSS.

2. DSS

The responsibilities of DSS are:

- the determination of initial and continuing eligibility for Medicaid and
- the enrollment of eligible persons in the Medicaid program.

3. Confidentiality

Medicaid applicants and recipients are protected by federal and state confidentiality regulations, 42 CFR 431.300 and 12VAC30-20-90. These regulations were established to protect the rights of clients to confidentiality of their Medicaid information.

a. Release of Client Information

Except as otherwise indicated, no person shall obtain, disclose or use, authorize, or permit the use of any client information that is directly or indirectly derived from the records, files or communications of the agency, except for purposes directly connected with the administration of the Medicaid program, which includes but is not limited to:

- establishing eligibility,
- determining the amount of medical assistance,
- providing services for recipients, and
- conducting or assisting in an investigation, prosecution or a civil or criminal proceeding related to the administration of the program.

Local agencies may release Medicaid numbers of recipients to medical providers during telephone conversations if the provider cannot contact the Medicaid provider/recipient verification telephone number. This procedure does not conflict with federal or State confidentiality regulations, if the local agency is satisfied that it is giving the Medicaid number to an identifiable provider.

b. Safeguarding Client Information

All information associated with an applicant or recipient that could disclose the individual's identity is confidential and shall be safeguarded. Such information includes but is not limited to:

- name, address, and all types of identification numbers assigned to the client;
- medical services provided to the client;
- social and economic conditions or circumstances of the client;
- agency evaluation of the client's personal information;
- medical data about the client, including diagnoses and past histories of disease or disabilities;
- information received for verifying income, eligibility, and amount of medical assistance payments;
- information received in connection with identification of legally liable third party resources; and
- information received in connection with processing and rendering decisions of recipient appeals.

c. Ownership of Records

All client information contained in the agency records is the property of the agency, and employees of the agency shall protect and preserve such information from dissemination except as indicated.

Original client records are not to be removed from the premises by individuals other than authorized staff of the agency, except by court order. The agency may destroy records pursuant to records retention schedules.

d. Release of Client Information with Consent

As part of the application process for Medicaid, the client shall be informed of the need to consent to the release of information necessary for verifying eligibility. Whenever a person, agency or organization that is not performing one or more of the functions described in 3.a above requests client information, the agency must obtain written permission to release the information from the client or the personal legally responsible for the client whenever possible. A release for information obtained from the client by the requesting agency also satisfies this requirement.

e. Release of Client Information without Consent

Information from the applicant/recipient's case record may not be released to other agencies, such as public housing agencies, legal services, private organizations, Immigration and Naturalization Services (INS), Virginia Employment Commission (VEC), school lunch programs, health departments or elected officials without the client's consent. An exception applies to agencies with which there is an agreement for specific types of sharing of information, such as wage information from the VEC, Systematic Alien Verification for Entitlements (SAVE) with INS, the State Verification Exchange System (SVES) with the Social Security Administration, etc.

Client information may be disclosed without client consent in these situations:

- to employees of state and local departments of social services for the purpose of program administration;
- to program staff in other states when a client moves or when there is a question of dual participation, or to verify the status of assistance in Virginia for applicants in another state;
- between state/local department of social services staff and DMAS for the purpose of supervision and reporting;
- to federal, state and local employees for the purposes of auditing, monitoring, and evaluation; and
- for the purpose of recovery of monies for which third parties are liable for payment of claims.

f. Clients Right of Access to Information

(1) Any client has the right to obtain personal information held by the agency. Upon written or verbal request, the client shall be permitted to review or obtain a copy of the information in his record with the following exceptions:

- Information that the agency is required to keep confidential from the client pursuant to §2.2-3704 and §2.2-3705, Code of Virginia, Virginia Freedom of Information Act, Public Records to be open to Inspection; and
- Information that would breach another individual's right to confidentiality.

(2) Consistent with the Virginia Freedom of Information Act, §2.2-3704 and §2.2-3705, Code of Virginia, the agency shall provide access within five working days after the receipt of the request. The agency shall make disclosures to applicants and recipients during normal business hours. Copies of the requested documents shall be provided to the client or a representative at reasonable standard charges for document search and duplication.

(3) The client shall be permitted to be accompanied by a person or persons of the client's choice and may grant permission verbally or in writing to the agency to discuss the client's file in such person's presence. Upon request and proper identification of any client or agent of the client, the agency shall grant to the client or agent the right to review the following:

- All personal information about the client except as provided in §2.2-3704 and §2.2-3705,
- The identity of all individuals and organizations not having regular access authority that request access to the client's personal information.

(4) Pursuant to the Code of Virginia §2.2-3800, a client may contest the accuracy, completeness or relevancy of the information in his record. Correction of the contested information, but not the deletion of the original information if it is required to support receipt of state or federal financial participation, shall be inserted in the record when the agency concurs that such correction is justified. When the agency does not concur, the client shall be allowed to enter a statement in the record refuting such information. Corrections and statements shall be made a permanent part of the record and shall be disclosed to any entity that receives the disputed information.

M0110.200 Definitions

A. Adult Relative means an individual who is age 18 or older, who is not a parent, but who is related to a child by blood or marriage and who lives with and assumes responsibility for day-to-day care of the child in a place of residence maintained as his or their own home.

B. Applicant means an individual who has directly or through his authorized representative made written application for Medicaid at the local social services department serving the locality in which he is a resident, or if institutionalized, the locality in which he last resided outside an institution.

C. Application for Medicaid means an official form prescribed by DMAS for requesting medical assistance that is used for initial eligibility determinations and redeterminations.

D. Attorney In Fact (Named in a Power of Attorney Document) means a person authorized by a power of attorney document (also referred to as a "POA") to act on behalf of another individual, either for some particular purpose or for the transaction of business in general. **A power of attorney document does not necessarily authorize the attorney in fact to apply for Medicaid on behalf of the applicant.** The eligibility worker must read the power of attorney document to determine (1) if the person has the power to act as the applicant in any of the applicant's business and (2) whether or not the document grants durable power of attorney. If the document is a general power of attorney or includes the power to conduct the applicant's financial business, the attorney in fact is considered the applicant's authorized representative as long as the person for whom the attorney in fact is authorized to act is not legally incapacitated.

If the individual on whose behalf the attorney in fact is acting is incapacitated and not able to act on his own behalf, the eligibility worker must examine the document to determine that it grants a durable power of attorney. The contents of the document must indicate that the power of attorney does not stop upon the incapacity of the person. **If the power of attorney is not durable, it is no longer valid when the individual on whose behalf it is executed becomes legally incapacitated.**

E. Authorized Representative means a person who is authorized in writing to conduct the personal or financial affairs for an individual. The authorized representative statement is valid until (1) the application is denied, or (2) Medicaid enrollment is cancelled, or (3) the applicant changes his authorized representative.

EXCEPTION: Patients in DMHMRSAS facilities may have applications submitted by DMHMRSAS staff.

F. Child means an individual under age 21 years.

G. Competent Individual means an individual who has not been judged by a court to be legally incapacitated.

H. Conservator means a person appointed by a court of competent jurisdiction to manage the estate and financial affairs of an incapacitated individual.

I. Family Substitute Representative means a spouse or designated relative who is willing and able to take responsibility for the individual's personal or financial affairs. Designated relatives other than the spouse who may be substitute representatives are, in this preferred order, the individual's adult child, parent, adult sibling, adult grandchild, adult niece or nephew, aunt or uncle.

J. Guardian means a person appointed by a court of competent jurisdiction to be responsible for the personal affairs of an incapacitated individual, including responsibility for making decisions regarding the person's support, care, health, safety, habilitation, education, and therapeutic treatment, and if not inconsistent with an order of commitment, residence.

K. Incapacitated Individual means an individual who, pursuant to an order of a court of competent jurisdiction, has been found to be incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (1) meet the essential requirements of his health, care, safety, or therapeutic needs without the assistance or protection of a guardian; or (2) manage property or financial affairs or provide for his or her support or the support of his legal dependents without the assistance or protection of a conservator.

L. Legal Emancipation of a Minor means a minor who has been declared emancipated by a court of competent jurisdiction. A married minor is not emancipated unless a court has declared the married minor emancipated from his parents.

M0110.300 Availability of Information

A. Information Required to be Given to the Applicant

1. Explanation of Medicaid Program

The agency must inform the applicant about Medicaid eligibility requirements, covered services, use of the Medicaid card, recovery (3rd party, lawsuits and estate) of funds paid, and the applicant's rights and responsibilities. This information must be given to the applicant in written form and verbally, if appropriate.

The following materials must be given to the individuals specified below:

- The booklet "Virginia Social Services Benefit Programs," form # 032-01-002, contains information about the Medicaid Program and must be given to all applicants.
- The Division of Child Support Enforcement (DCSE)'s booklet "Child Support and You," form #032-01-945 must be given to applicants who are applying on behalf of a child who has an absent parent.
- The "Virginia Medicaid Handbook" must be given to all recipients and must be given to others upon request.

Applicants may also be given Medicaid Fact Sheets as appropriate.

2. Early Periodic Screening, Diagnosis and Treatment (EPSDT)

All Medicaid applicants who are under age 21 are eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. Information on the availability and benefits of EPSDT must be provided for all applicants under age 21 within 60 days of the date that eligibility is determined. EPSDT information is included in the booklet "Virginia Social Services Benefit Programs."

3. Voter Registration

The National Voter Registration Act of 1993 (NVRA) requires local social services agencies to offer each TANF, Food Stamp, and Medicaid applicant an opportunity to apply to register to vote at initial application and at each review of eligibility. Additionally, voter registration application services must be provided any time a change of address is reported in person to the local agency.

In complying with the requirements of the NVRA, local agency staff must provide each applicant and applicant the same degree of assistance in completing his/her voter registration application as they do in completing the application for public assistance.

a. Exceptions to Offering Voter Registration

The only exception to offering voter registration application services is when the applicant:

- has previously indicated that he/she is currently registered to vote where he/she lives,
- there is a completed agency certification form in the applicant's case record indicating the same, and
- the applicant has not moved from the address where he/she stated that he/she was registered to vote.

b. Voter Registration Application Sites

Local social services agencies are required to offer voter registration application services at each local office (including satellite offices) for applicants/recipients of TANF, Food Stamp, and Medicaid assistance. Voter registration application services are also offered by out-stationed staff taking Medicaid applications at hospitals or local health departments and by Medicaid staff at the state's Mental Health, Mental Retardation, and Substance Abuse facilities.

B. Information Made Available to the Public in General

1. Availability of Manual

Federal regulations require copies of the State Plan and eligibility rules and policies to be available in agency offices and other designated locations. Policy manuals must be made available in agency offices and other designated locations to individuals who ask to see them.

Upon request, copies of program policy materials must be made available without charge or at a charge related to the cost of reproduction. Copies of manual pages may be made at the local departments of social services, or Medicaid manuals may be ordered from:

Virginia Department of Social Services
Division of General Services
730 East Broad Street,
Richmond, Virginia 23219

2. Medicaid Handbook and Fact Sheets

Federal regulation 42 CFR 435.905 requires the state agency to publish bulletins or pamphlets describing eligibility in easy to understand language. The "Virginia Medicaid Handbook" includes basic information about the program and provides a listing of rights and responsibilities. To supplement the "Virginia Medicaid Handbook," fact sheets that explain specific policy areas are available to local social services agencies from the state department of social services. The “Virginia Medicaid Handbook” will be given to all recipients at initial approval and to other individuals upon request. The handbook is also available on the internet at www.dmas.state.va.us.

C. Inquiries

1. General Inquiries

The following information has been developed to give guidance to employees of the State and local departments of social services about how to respond to inquiries:

- Limit verbal and written information to explaining the written materials provided. Those written materials may include copies of manual pages, the “Virginia Medicaid Handbook,” or fact sheets. The individual may also be referred to the Virginia Department of Social Services website at www.dss.state.va.us and the Virginia Department of Medical Assistance Services website at www.dmas.state.va.us for additional information.

- Do not go beyond the scope of the written materials. Questions about hypothetical situations, such as (but not limited to) "what would happen if a certain value of resources were transferred?" or "what would be the effect on Medicaid if a trust were written in a certain way?" cannot be answered.

Medicaid rules and policies are applied to the facts of a specific application after an application is received. Prior to receipt, do not give hypothetical advice or answers to hypothetical questions to applicants, their attorneys or anyone applying on behalf of the applicant. Answering hypothetical questions is inappropriate for two reasons:

- Until a complete application is received, the local agency cannot be sure it has all the relevant facts. An attempt to be helpful could be futile or lead to incorrect advice. In the event of a dispute, the applicant may then assert that the agency is bound by the incorrect advice. The applicant or other persons affected by the applicant's actions (such as those affected by a property transfer or those otherwise responsible for the care of the applicant) may attempt to hold the agency employee or employees involved individually liable for damages suffered as a result of alleged negligent advice.

- Providing responses to hypothetical questions may under some circumstances constitute the practice of law. The practice of law includes advising another for compensation, direct or indirect, in any matter involving the application of legal principles to facts or purposes or desires. Local agency workers, regional Medicaid consultants, and central office Medicaid employees, even if they are attorneys, are not functioning as legal counsel and must not give legal advice which may affect the rights of applicants, recipients, or others who may not be applying or eligible for Medicaid.

All Medicaid staff are bound by these guidelines for the dissemination of information. Do not refer inquiries from attorneys, applicants or others acting on behalf of the applicant to regional or state Medicaid staff.

2. Case Specific Inquiries

Send questions that occur as a direct result of the receipt of an application to the regional Medicaid consultant. Do not refer questions from attorneys (or legal questions in general) to the Regional Assistant Attorney General. These attorneys are responsible for providing legal advice to the regional Medicaid consultant and are not authorized to give legal advice to the public.

CHAPTER M01
MEDICAID APPLICATION
SUBCHAPTER 20

REQUEST FOR ASSISTANCE

TABLE OF CONTENTS

M01 MEDICAID APPLICATION

M0120.000 Request for Assistance

Appendices

M0120.000 Request for Assistance

M0120.100 Right to Apply

An individual cannot be refused the right to complete an application for himself (the applicant) or any other individual for whom he is authorized to apply, and under no circumstances can an individual be discouraged from asking for assistance for himself or any person for whom he is a legally responsible or authorized to represent. An applicant may be assisted with the application by an individual of his choice. A face-to-face interview is not required.

M0120.200 Who Can Sign the Application

A. Patients in DMHMRSAS Facilities

Patients of any age in the DMHMRSAS facilities may have applications submitted and signed by DMHMRSAS staff. The DMHMRSAS facilities are listed in subchapter M1550.

B. Applicants Age 18 or Older

The applicant must sign the application, even if the form is filled out by another person, unless the application is filed and signed by the applicant's legal guardian, conservator (known as the "committee" for persons declared incompetent prior to the 1997 changes in the guardianship section of the Code of Virginia), attorney in fact, or authorized representative. If the applicant cannot sign his or her name but can make a mark, the mark must be correctly designated (the individual's first and last name and the words "his mark" or "her mark" must be printed adjacent to the mark) and witnessed by one person as in the example below:

E.g.: (X) John Doe, his mark

Witness's signature:_____

1. Family Substitute Representative

When it is reported that an applicant cannot sign the application and the applicant does not have a guardian, conservator, attorney in fact or designated authorized representative, one of the individuals listed below who is willing to take responsibility for the applicant's Medicaid business will be the applicant's "family substitute" representative. The family substitute representative will be, in this preferred order, the applicant's:

- spouse,
- adult child,
- parent,
- adult sibling,

- adult grandchild,
- adult niece or nephew, or
- aunt or uncle.

2. No Family Substitute Representative

If the applicant is unable to sign the application and does not have an attorney in fact, authorized representative, or family substitute representative, the applicant's inability to sign the application must be verified. Verification is by a written statement from the applicant's doctor that says that the applicant is not able to sign the Medicaid application because of the applicant's diagnosis or condition. Follow these procedures:

a. Determine if anyone has begun the process to have a guardian or conservator appointed for the applicant.

b. If action has been initiated to obtain a guardian for the applicant, meaning a court guardianship hearing is scheduled on the court docket, request verification that the action is on the court docket. Give 10 days for this verification to be provided.

If the verification is provided within the 10 day period, continue to pend the application until the guardian or conservator is appointed. If the application pends for 45 days, send a Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs (NOA), form #032-03-003, to the applicant to extend the pending application.

Once the guardian/conservator has been appointed, request verification of the appointment and that the application be signed by the guardian or conservator. Retain a copy of the application and mail the original application to the guardian/conservator. Allow 10 days for the signed application and guardian/conservator papers to be returned. If the application form and guardian/conservator papers are not returned to the agency by the specified date, deny the application because it is invalid.

c. If guardianship/conservator procedures have not begun or have not been verified as being on the court docket, refer the applicant to Adult Protective Services (APS) in the local agency.

If the report to APS meets all criteria for a valid report, an investigation will be conducted to learn whether protective services are needed and, if so, what services are needed. The protective services identified will be provided or arranged by APS.

Continue to pend the application until the APS investigation is completed. If the completed APS investigation concludes that guardianship proceedings will not be initiated, the application must be signed by the applicant, or the applicant must sign a statement designating an authorized representative. Give the applicant 10 working days to return the signed application to the agency.

d. If the application form is not signed by the applicant or the authorized representative and returned to the agency by the specified date, deny the application because it is invalid.

3. Procedure for Who Can Sign the Application

When preparing to determine the Medicaid eligibility of an individual age 18 or older, examine the application to determine if the applicant can complete and sign the application form or if the applicant has an authorized representative. Ask the following questions:

Has the applicant been judged legally incapacitated by a court of law, as evidenced by a copy of the conservator or guardian certificate of appointment in the record?

YES: The authorized representative is the appointed conservator or guardian. STOP.

NO: The applicant is competent. Does the applicant have an attorney in fact who has the power of attorney to apply for Medicaid for the applicant as evidenced by a copy of the power of attorney document in the record?

YES: The authorized representative is the attorney in fact. STOP.

NO: Has the applicant signed a written statement authorizing a person (or staff of an organization) to apply for Medicaid on his behalf?

YES: The authorized representative is the person or organization authorized by the applicant to represent him. STOP.

NO: Is the applicant able to sign or make a mark on a Medicaid application form?

YES: Ask the applicant for his signature or mark on the application form or for a written statement authorizing someone to apply for Medicaid on his behalf. Give the applicant 10 working days to return the completed and signed form(s). If the completed and correctly signed form(s) are not returned by the specified date, DENY MEDICAID because of an invalid application.

NO: Does the applicant have at least one of the following:

- spouse,
- adult child,
- parent,
- adult sibling,
- adult grandchild, adult niece or nephew, or
- aunt or uncle?

YES: The authorized representative is the individual identified above who is willing and able to act on the applicant's behalf.

NO: Verify the inability of the applicant to sign the application because of a diagnosis or condition through a written statement from the applicant's doctor. Refer to APS. Pend the application. At the conclusion of the APS investigation, if APS concludes that guardianship proceedings will not be initiated, the applicant must sign or make a mark on the application or designate an authorized representative in writing. If the signed application form is not received by the specified date, deny Medicaid.

C. Applicants Under Age 18

1. Child Applicant

A child who is under age 18 years is not legally able to sign a Medicaid application for himself unless he is legally emancipated from his parents. If the child is not legally emancipated, one of the following must sign the application:

- his parent,
- legal guardian,
- authorized representative, or
- an adult related by blood or marriage with whom the child lives (documentation of the relationship is not required).

If the child is married and living with his spouse who is age 18 or older, the child's spouse may sign the application.

a. No Guardian or Legal Custody

If the child does not live with a parent or an adult relative and no adult is the child's guardian or has legal custody of the child, whoever is caring for the child is responsible for seeking custody or guardianship of the child in the Juvenile and Domestic Relations court. Determine if the person submitting the application, or another person, has begun the process to obtain legal guardianship or custody of the child applicant.

b. Action Is Initiated To Appoint Guardian/Award Custody

If action has been initiated to appoint a guardian for or seek legal custody of the child, meaning a court guardianship or custody hearing is scheduled on the court docket, request verification that the action is on the court docket. Give 10 days for this verification to be provided.

If the verification is provided within the 10 day period, continue to pend the application until a guardian is appointed or custody is awarded. If the application pends for 45 days, send a notice to the applicant to extend the pending application.

Once the guardian has been appointed or custody awarded, request verification of the appointment or award and that the application be signed by the guardian or adult who was awarded custody. Allow 10 days for the signed application and guardianship or custody papers to be returned.

If the court refuses to appoint a guardian or custodian, deny the application as invalid.

c. Action Not Initiated – Refer to Child Welfare Services

If guardianship or custody procedures have not begun or have not been verified as being on the court docket, refer the child to the appropriate Child Welfare service worker.

Continue to pend the application until the service investigation is completed and any court proceedings are completed. Once the guardian has been appointed or custody awarded, request verification of the appointment or award and that the application be signed by the guardian or adult who was awarded custody. Retain a copy of the application and mail the original application to the guardian or custodian. Allow 10 days for the signed application and guardian or custody papers to be returned.

If the child was emancipated by the court, request the child's signature on the application. If the application is mailed to the child, allow 10 days for the signed application form to be returned.

If the application form is not signed by the applicant, the guardian or custodial adult and returned to the agency by the specified date, deny the application because it is invalid.

2. Minor Parent Applying for His Child

A parent under age 18 years may apply for Medicaid for his own child because he is the parent of the child.

3. Foster Care Child

The Medicaid application for a child under age 18 who is in foster care must be signed by an authorized employee of the public or private agency that has custody of the child. If there is a non-custodial agreement, the parent or legal guardian must sign the Medicaid application.

D. Deceased Applicant

1. An application may be made on the behalf of a deceased person within a three-month period subsequent to the month of his death if both of the following conditions are met:

   - the deceased received a Medicaid-covered service on or before the date of death, and
   - the date of service was within a month covered by the Medicaid application.

2. If the above conditions are met, an application may be made by any of the following:

   - his guardian or conservator,
   - attorney in fact,
   - executor or administrator of his estate,
   - his surviving spouse, or
   - his surviving family member, in this order of preference: adult child, parent, adult brother or sister, adult niece or nephew, or aunt or uncle.

Under no circumstances can an employee of, or an entity hired by, the medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of a deceased individual.

Medicaid coverage can begin no earlier than three months prior to the application month. The entitlement rules for retroactive coverage apply to the application's retroactive period.

E. Unsigned Application

An application that bears no signature is invalid. Return the application to the applicant with a letter requesting a signature.

F. Invalid Signature

An application that is signed by an individual who is not authorized to sign on behalf of the applicant is invalid. Return the application with a letter indicating who must sign the application to the individual who filed the application on behalf of the applicant. See M0120, Appendix 1 for a sample letter.

M0120.300 Medicaid Application Forms

A. General Principle

A signed application is required for all initial requests for medical assistance. The Request for Assistance---ADAPT---, form #032-03-875 (see M0120, Appendix 2) may be used to establish and preserve the application date, but a signed application must be submitted in order for eligibility to be determined.

A child born to a mother who was Medicaid eligible at the time of the child's birth, *including a child born to an emergency services alien certified for Medicaid payment for labor and delivery*, is deemed to have applied and been found eligible for Medicaid on the date of the child's birth. An application for the child is not required. The child remains eligible for Medicaid to age 1 year so long as the mother remains eligible for Medicaid, or would be eligible if she were *still* pregnant, and they live together.

B. Medicaid Application Forms

An applicant may obtain a prescribed application form from a number of sources, including a variety of human service agencies, hospitals, and the internet.

There are specialized forms intended for use with certain covered groups, including medically indigent pregnant women, children, SSI recipients, and women who have been screened under the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). These forms should be used whenever possible because they do not ask the applicant to provide information that is not used in the eligibility determination.

Appendices 3 through 8 of this chapter contain sample prescribed Medicaid application forms. Other forms that serve as Medicaid application forms are listed in section M0120.300.D.

The following forms have been prescribed as application forms for Medicaid:

- Application for Benefits, form #032-03-824, also referred to as the Combined application, may be used by any applicant (see M0120, Appendix 3).
- Application/Redetermination for Medicaid for SSI Recipients, form #032-03-091 (see M0120, Appendix 4);
- Medicaid Application/Redetermination for Medically Indigent Pregnant Women, form #032-03-040 (see M0120, Appendix 5);
- Application for Children's Health Insurance in Virginia, form FAMIS-1 (see M120, Appendix 6);
- *Health Insurance for Children and Pregnant Women, form FAMIS-2* (see M0120, Appendix 6a);
- Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384, is used only by women screened under the Breast and Cervical Cancer Early Detection Program. This form is not to be given to applicants by the local departments of social services (M0120, Appendix 7 is provided for reference purposes);
- Signed ADAPT Statement of Facts (SOF). If any additional information is necessary (individual requires a resource evaluation), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant and attached to the SOF.
- Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636 (see M0120, Appendix 8).

C. Other Medicaid Applications

1. Auxiliary Grant (AG)

An application for AG is also an application for Medicaid. A separate Medicaid application is not required.

2. Title IV-E Foster Care (FC) and Medicaid Application/ Redetermination (Form #032-03-636)

For a FC child whose custody is held by a local department of social services or a private FC agency or for an adoption assistance (AA) child, the Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636 is used to determine if the child meets IV-E eligibility requirements. This form is also used to determine Medicaid eligibility for IV-E FC and AA children and non-IV-E FC children in the custody of a local agency in Virginia. This form is not used for children in non-custodial agreement cases or non-IV-E AA. When a child enters care through a non-custodial agreement or is a non-IV-E AA child, a separate Medicaid application must be completed and signed by the parent or guardian.

For IV-E FC children in the custody of another state's social services agency and IV-E AA children, a separate Medicaid application is not required. The worker must verify the IV-E maintenance payment (for FC) or the IV-E status (for AA). Virginia residency (by declaration) and current third party liability (TPL) information must be obtained. This information may be supplied by the foster/adoptive parent or obtained from the agency that entered into the FC or AA agreement. For Non IV-E AA children, the parent must file a separate application.

M0120.400 Place of Application

A. Principle

The place of application is ordinarily the office of the local social service department serving the locality in which the applicant resides. Verification of residence is not required. Medicaid applications are also taken at designated hospitals and health clinics (Medicaid outstationed sites). If an applicant is homebound and needs assistance with completing the application, the agency, upon request, must arrange to have the application taken where he resides or is a patient.

A child whose residence is divided between two custodial parents living in different localities is considered to reside in the locality in which he attends school. If the child is not enrolled in school, the parents must decide which locality is the child's residence for Medicaid application/ enrollment purposes.

B. Children in State and Local Custody

Responsibility for taking applications and maintaining the case belongs as follows:

1. Foster Care

a. Title IV-E Foster Care

Children in the custody of a Virginia local department of social services or private foster care agency who receive Title IV-E maintenance payments apply at the agency that holds custody.

Title IV-E foster care children in the custody of another state's social services agency apply in the Virginia locality where they reside.

b. State/Local Foster Care

Non-Title IV-E (state/local) children in the custody of a Virginia local department of social services or a private child placing agency apply at the agency that holds custody.

Children in the custody of another state's social services agency who are not Title IV-E eligible do not meet the Virginia residency requirement for Medicaid and are not eligible for Medicaid in Virginia (see M0230).

2. Adoption Assistance

Children receiving adoption assistance through a Virginia local department of social services apply at the agency that made the adoption assistance agreement.

Children receiving adoption assistance through another state's social services agency apply at the local department of social services where the child is residing.

3. Va. Department of Juvenile Justice/Court (Corrections Children)

Children in the custody of the Virginia Department of Juvenile Justice or who are the responsibility of a court (corrections children) apply at the local agency where the child is residing.

C. Institutionalized Individual (Not Incarcerated)

When an individual of any age is a resident or patient in a medical or residential institution, except DMHMRSAS facilities and the *Virginia Veteran's Care Center*, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in Virginia in which he last resided outside of an institution.

Exception: If the applicant is applying for or receives food stamps, responsibility for processing the Medicaid application and determining Medicaid eligibility rests with the department of social services in the locality in which the institution where he is receiving care is located.

If the individual did not reside in Virginia prior to entering an institution, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in which the institution where he is receiving care is located.

D. Individuals in DMHMRSAS Facilities

1. Patient in a DMH-MRSAS Facility

If an individual is a patient in a state DMHMRSAS institution, is not currently enrolled in Medicaid, and is eligible in an Aged, Blind or Disabled (ABD) covered group, responsibility for processing the application and determining eligibility rests with the state department of social services' eligibility technicians located in DMHMRSAS facilities. A listing of facilities and technicians as well as further information on the handling of cases of Medicaid applicants and recipients in DMHMRSAS facilities is located in Subchapter M1550.

If an individual is a patient in a State DMHMRSAS Institution, is not currently enrolled in Medicaid, and is eligible in a Families and Children's (F&C) covered group, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in Virginia in which he last resided outside of an institution.

2. Patient Pending Discharge

a. General Policy

For DMHMRSAS facility patients who will be discharged, local agencies will take the applications received on behalf of these patients and process them within the established time frames. Eligibility will be determined based on the type of living arrangement to which the patient will be discharged.

If the patient was not Medicaid eligible in the DMHMRSAS facility but Medicaid eligibility in the patient's new circumstances needs to be determined, an application must be sent to the appropriate department of social services. The facility physician or discharge planning authority must attach a written statement that includes the following information:

- the date of the proposed discharge,
- the type of living arrangement and address to which the patient will be discharged (nursing facility, adult care residence, private home, relative's home, etc.), and
- the name and title of the person who completed the statement.

If the patient is found eligible, he is not enrolled in the Medicaid program until he has been discharged from the institution.

b. Pending Discharge to a Facility

If a patient who was not Medicaid eligible in the DMHMRSAS facility is being discharged to an assisted living facility or nursing facility, an application for Medicaid will be filed with the department of social services in the locality in which the patient last resided prior to entering an institution.

c. Pending Discharge to the Community

If a patient who was not Medicaid eligible in the DMHMRSAS facility will live outside of an institution, the responsibility for processing the application and determining eligibility rests with the locality in which he will be living.

E. Virginia Veteran's Care Center

Medicaid applications for patients in the Virginia Veteran's Care Center in Roanoke may be filed, processed and maintained at the Roanoke City Department of Social Services.

***F.* Incarcerated Individuals**

Inmates of state correctional facilities may apply for Medicaid as part of pre-release planning. Responsibility for processing the application and determining eligibility rests with the local department of social services in the locality where the inmate was living prior to incarceration. Applications are to be processed in the same manner and within the same processing time standards as any other Medicaid application, but if the incarcerated individual is found eligible, he is not enrolled in the Medicaid program until after he has been released from the correctional facility. Applications are not to be refused because an applicant is an inmate of a public institution at the time of application.

The following procedures will be followed by correctional facility staff when an inmate in a Virginia Department of Corrections facility will require placement in a nursing facility upon release:

- The correctional facility staff will complete the Medicaid application and, if *a disability determination is* needed, *the disability report* and medical release forms. The correctional facility staff will notify the assigned Medicaid consultant and mail the forms to the local department of social services in the locality where the inmate was living prior to incarceration.

- The correctional facility staff will request a pre-admission screening for nursing home care from the health department or local department of social services in the locality where the correctional facility is located. This screening is to be done simultaneously with the determination of disability and determination of Medicaid eligibility. The staff will coordinate with nursing facilities in order to secure a placement.

M0120.500 Receipt of Application

A. General Principle

An applicant or authorized representative may submit a written application for Medicaid only or may apply for Medicaid in addition to other programs.

An applicant may be assisted with completing the various aspects of the application by an individual(s) of his choice and may designate in writing that such individual(s) may represent him in subsequent contacts with the agency.

B. Application Date

The application date is the earliest date the signed, written application for Medicaid or the Request for Assistance is received by the local agency, an outstationed site, or an entity contracted with DMAS to accept applications. The application must be on a form prescribed by DMAS and signed by the applicant or person acting on his behalf. The application may be received by mail, fax, or hand delivery. The date of delivery to the agency must be stamped on the application. If an application is received after the agency's business hours, the date of the application is the next business day.

The date of application for foster care children in the custody of a local department of social services is the date the application is received by the eligibility worker.

If an application for a pregnant woman or child is denied due to excess income, the applicant must be given the opportunity to complete an Application for Benefits in order to request a medically needy evaluation. If the Application for Benefits is submitted within 10 days of the date the notice of denial was mailed, the application date is protected, and the date of application is the date the denied application was received.

Commonwealth of Virginia
Department of Social Services

NOTICE REGARDING MEDICAID APPLICATION REQUIREMENTS

A Medicaid application has been filed on the behalf of _____ (name of applicant). However, the application is not valid and cannot be processed because the application must be signed by one of the following persons:

- the parent of a person under age 18,
- the adult who is the legal guardian or has legal custody of a person under age 18,
- any adult related by blood or marriage with whom a person under age 18 lives,
- the person for whom Medicaid is requested if the person is over age 18 or an emancipated minor,
- the authorized representative for the person who is requesting assistance, who may be
  - any person to whom he/she has legally given power of attorney, or
  - any person who he/she has designated by a signed written statement to apply on his/her behalf for Medicaid or public benefits, or
- the guardian, conservator, or committee of a person over age 18 who has been judged legally incapacitated by a court of law.

Please return the signed application and the authorized representative statement (if needed) by _____ so that the application may be processed. Thank you.
(date)

_____ _____
Signature Date

_____
Title

_____
Agency Name

_____
Phone Number

Commonwealth of Virginia
Department of Social Services
REQUEST FOR ASSISTANCE
--- ADAPT ---

GENERAL INFORMATION

This Request for Assistance is the first part of the application process. You must also complete the second part of the application process by (1) having an interview, or (2) completing an Application for Benefits form, or the appropriate Medicaid application

With this Request for Assistance, you can begin the application process for one or more of the following assistance programs. You can also use this Request to request a Medicaid resource assessment for long term care.

- Food Stamps
- Temporary Assistance for Needy Families (TANF)
- Medicaid
- General Relief
- Emergency Assistance
- State and Local Hospitalization
- Auxiliary Grants
- Refugee Resettlement Program

COMPLETE AND ACCURATE INFORMATION

You must give complete, accurate, and truthful information. If you refuse to give needed information, your eligibility for assistance may not be able to be determined. Information regarding your race is not required, but if you decide not to give this information, your worker will complete that section. If you knowingly give false, incorrect or incomplete information, or fail to report changes, you could lose your benefits and be arrested, prosecuted, fined and/or imprisoned. If you knowingly give false, incorrect, or incomplete information in order to help some else receive benefits, you could be arrested and prosecuted for fraud. You must also provide required verifications.

The Virginia Department of Social Services is an equal opportunity provider.

SPECIAL INFORMATION FOR FOOD STAMP APPLICANTS

You can begin the application process for Food Stamps by completing this Request for Assistance or by completing only the information in the boxes below and providing at least your **name, address, and signature.** You must complete the rest of this application process before your eligibility can be determined.

You must also be interviewed. Under certain hardships, you can be interviewed by telephone. You may turn in this Request for Assistance before your are interviewed. This is important because if you are eligible for the month in which you apply, your food stamp amount will be based on the date you actually turn in your Request.

EXPEDITED SERVICE FOR FOOD STAMPS

Your household may qualify for Expedited Service and receive food stamps within 7 days if you are eligible and your gross monthly income is less than $150 and liquid resources are $100 or less; or your monthly shelter bills are higher than your household's gross monthly income plus your liquid resources; or your household is a migrant or seasonal farmworker household with little or no income and resources. **GIVE THE INFORMATION REQUESTED IN THE BOXES BELOW, SO YOUR ELIGIBILITY FOR EXPEDITED SERVICE CAN BE DETERMINED.**

Total money expected this month before deductions	$_____
Total cash, money in checking/savings accounts, CDs	$_____
Total rent or mortgage for this month	$_____
Total utility expenses for this month	$_____
Do no count amounts due for previous months. Count only the basic telephone service cost.	
Is anyone in your household a migrant or seasonal farmworker	YES ( ) NO ( )

NAME	DATE OF BIRTH
ADDRESS	SOCIAL SECURITY NUMBER
	TELEPHONE
SIGNATURE	DATE

VERIFICATION OF INFORMATION

The information that you give may be matched against Federal, State, and local records including the Virginia Employment Commission and the Department of Motor Vehicles to determine if it incorrect, accurate, and truthful. In addition, your Social Security Number will be used to verify your identity, prevent receipt of benefits from more than one social service agency at the same time, and make required program changes.

The INCOME AND ELIGIBLITY VERIFICATION SYSTEM (IEVS) will also be used to verify information. This system uses your SSN to verify wages and salary, unemployment benefits, and unearned income by using records from the Internal Revenue Service and the Social Security Administration. The State Verification Exchange System (SVES) uses your SSN to verify your receipt of social security and Supplement Security Income (SSI) benefits. It is also used to verify quarters of coverage under Social Security, if you are an alien. In addition, the Immigration and Naturalization Service (INS) will be used to verify the status of aliens. Any difference between the information you give and these records will be investigated. Information from these records may affect your eligibility and benefit amount. If a food stamp claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

VIRGINIA SOCIAL SERVICES – TEMPORARY ASSISTANCE PROGRAM BOOKLET

This booklet contains information about the programs available at your local social services agency plus other very important information you should know, including your responsibilities. READ THIS BOOKLET CAREFULLY. Refer to the APPEALS Section if you have a complaint about an action taken on your case.

COMPLETING THE REQUEST FOR ASSISTANCE

If you need help completing this Request for Assistance, a friend or relative or your eligibility worker can help you. If you are completing this Request for someone else, answer each question as if you were that person. If you need to change an answer or make a correction, write the correct information nearby and put your initials and date next to the change. If more than 6 people are living in your home and you need more space to list everyone, tell the agency you need extra pages.

FILING A REQUEST FOR ASSISTANCE

You may turn in a partially completed Request for Assistance which contains at least your **name, address, and signature** (or the signature of your authorized representative), but you must complete the rest of the application process before your eligibility can be determined. For some programs, you must also be interviewed, but you may turn in your Request for Assistance before your interview.

You may turn in your Request for Assistance any time during office hours the same day you contact your local social services agency. You have the right to turn in your Request for Assistance, even it looks like you may not be eligible for benefits.

AGENCY USE ONLY

EXPEDITED SERVICE DETERMINATION

Income less than $150 and Resources $100 or less **YES ( ) NO ( )**

Income plus resources less than shelter bills
YES ( ) NO ( )

For migrants or seasonal farmworkers:

Resources $100 or less, and in next 10 days $25 or less is expected from new income:

OR

Resources $100 or less, and no income is expected from a terminated source for the rest of this month or next month. **YES ( ) NO ( )**

EXPEDITE IF <u>YES</u> TO ANY OF THE ABOVE

Commonwealth of Virginia
Department of Social Services
REQUEST FOR ASSISTANCE
--- ADAPT ---

AGENCY USE ONLY			
CASE NAME	CASE NUMBER(S)	PROGRAM(S)	REGISTRATION NUMBER
APPLICATION TYPE	LOCALITY	WORKER	CASELOAD NUMBER
DATE OF SERVICE REFERRAL		DATE RECEIVED	

1.

APPLICANT'S NAME	C/O NAME	PHONE NUMBER (HOME/MESSAGES) (WORK)
RESIDENCE ADDRESS (INCLUDE CITY, STATE AND ZIP)	MAILING ADDRESS (IF DIFFERENT)	DIRECTIONS TO HOME

2. Check (√) your household's primary language: ( ) English ( ) Spanish ( ) Cambodian ( ) Vietnamese ( ) Other_____

3. **LIST EVERYONE LIVING IN YOUR HOME,** even if you are not requesting assistance for that person. List yourself on the first line. If you are married, list your spouse on the second line. Then list everyone else. Provide the information required for each person listed. Check (√) type of assistance requested for each person. If no assistance is requested, check **NONE** for that person. A Social Security Number and an Alien Registration Number do not have to be provided for any individual for whom assistance is not being requested.

NAME First MI Last Suffix (Jr., Sr.)	SEX M,F	RACE SEE* BELOW	ETHNICITY SEE** BELOW	DATE OF BIRTH	SOCIAL SECURITY NUMBER	ALIEN REGISTRATION NUMBER	FOOD STAMPS	TANF	MEDICAID	GENERAL RELIEF	EMERGENCY ASSISTANCE	STATE & LOCAL HOSPITALIATION	AUXILIARY GRANTS	REFUGEE RESETTLEMENT PROGRAM	MEDICAID RESOURCE ASSESSMENT	NONE	THIS PERSON'S RELATIONSHIP TO YOU	AGENCY USE ONLY CLIENT ID
(Your Name)																		
(Your Spouse's Name, if you are married)																		

* RACE: (Not required) Use these codes to indicate RACE: 1 – White, 2 – Black or African American, 3 – American Indian or Alaska Native, 4 – Asian, 5 – Native Hawaiian or Pacific Islander.
** ETHNICITY: (Not required) Use these codes to indicate ETHNICITY: 1 – Hispanic or Latino, 2 – Not Hispanic or Latino

4. List anyone from #3 above who is pregnant_____
or who is disabled:_____
5. List anyone from #3 above who is requesting Medicaid who had medical treatment during the 3 months before this request:_____

6. YES ( ) NO ( ) Have you or anyone for whom you are applying ever applied for or received or are currently receiving any benefits from a social services agency, including Food Stamps, AFDC, TANF, Medicaid, General Relief, Auxiliary Grants, Foster Care, Adoption Assistance, Refugee Other or Refugee Medicaid Other?

Person Who Applied for or Received Benefits	Under What Case Name	Type of Benefits Received
When	From What County or City of State	

7. YES ( ) NO ( ) Does anyone have any of the following emergencies? If **YES,** check (✓) the type of emergency and explain the cause.
( ) Food ( ) Shelter ( ) Medical ( ) Clothing ( ) Other Emergency_____
Cause: _____

8. YES ( ) NO ( ) Is there anything that you would like to talk about with a service worker? This could include concerns about your children, school problems, day care needs, family planning, family violence, referrals to other community organizations, or other problems or concerns. If **YES**, explain.

Explain:

BY MY SIGNATURE BELOW I DECLARE, UNDER PENALTY OF PERJURY, THAT ALL OF THE FOLLOWING ARE TRUE:
I understand:

- All of the information in the GENERAL INFORMATION Section on pages 1 and 2.
- If I give false, incorrect, or incomplete information, I may be breaking the law and could be prosecuted for perjury, larceny, or welfare fraud.
- If I helped someone else complete this form so as to get benefits he or she is not entitled to receive, I may be breaking the law and could be prosecuted.

I received the Temporary Assistance Programs Booklet **YES ( ) NO ( )** **MEDICAID APPLICANTS:** I received the Virginia Medicaid Handbook **YES ( ) NO ( )**

All information I gave on this Request for Assistance is correct and complete to the best of my knowledge and belief. I authorize the release to this agency of all information necessary to determine my eligibility.

I filled in this Request for Assistance myself. **YES ( ) NO ( )** If **NO**, it was read back to me when completed. **YES ( ) NO ( )**

APPLICANT OR AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK	DATE	WITNESS TO MARK OR INTERPRETER	DATE

COMPLETE THE BOX BELOW IF THIS REQUEST FOR ASSISTANCE WAS COMPLETED FOR THE APPLICANT BY SOMEONE ELSE:

NAME OF PERSON COMPLETING APPLICATION	DATE	ADDRESS
PHONE NUMBER (HOME) (WORK)		RELATIONSHIP TO APPLICANT

REQUEST FOR ASSISTANCE

FORM NUMBER - 032-03-875

PURPOSE OF FORM - To indicate an intent to apply for benefits by applicant.

USE OF FORM - To be completed by an applicant to begin the application process through the ADAPT system. The form completed with the applicant's name, address and signature will secure the application date regardless of the eventual date of completion of the interactive interview and signed Statement of Facts. The form will also allow an evaluation of entitlement to expedited service processing.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The form must be retained in the case record with the appropriate Statement of Facts.

INSTRUCTIONS FOR PREPARATION OF FORM - General instructions appear of the form for completion.

If changes need to be made after the application is completed, the applicant should write the revised information near the original entry. The applicant must initial and date the changes. Except for agency-use sections, eligibility workers may not add to or write on a completed application.

Commonwealth of Virginia
Department of Social Services

APPLICATION FOR BENEFITS

GENERAL INFORMATION

With this application, you can apply for one or more of the following assistance programs. Refer to the fold-out page for instructions.

- Food Stamps
- Temporary Assistance for Needy Families (TANF)
- Medicaid/FAMIS Plus/FAMIS
- General Relief
- Emergency Assistance
- State and Local Hospitalization
- Auxiliary Grants
- Refugee Resettlement Program

VERIFICATION AND USE OF INFORMATION

The information that you give may be matched against Federal, State and local records including the Virginia Employment Commission and the Department of Motor Vehicles to determine if it is correct, accurate, and truthful. In addition, your Social Security Number (SSN) will be used to verify your identity, prevent receipt of benefits from more than one social service agency at the same time, and make required program changes.

The INCOME AND ELIGIBILITY VERIFICATION SYSTEM (IEVS) will also be used to verify information. This system uses your SSN to verify wages and salary, unemployment benefits, and unearned income by using records from the Internal Revenue Service and the Social Security Administration. The State Verification Exchange System (SVES) uses your SSN to verify your receipt of social security and Supplemental Security Income (SSI) benefits. It is also used to verify quarters of coverage under Social Security, if you are an alien. In addition, the Immigration and Naturalization Service (INS) will be used to verify the status of aliens. Any difference between the information you give and these records will be investigated. Information from these records may affect your eligibility and benefit amount. If a food stamp claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

032-03-824/16 (6/03)

SPECIAL INFORMATION FOR FOOD STAMP APPLICANTS

You can apply for Food Stamps by leaving a completed Application for Benefits at the agency or by leaving a partially completed Application with at least your name, address, and signature, or by tearing off and leaving this half-sheet with your name, address, and signature. **You must complete the rest of this Application before your eligibility can be determined.**

You must also be interviewed. Under certain hardships, you can be interviewed by telephone. You may turn in your application before you are interviewed. This is important because if you are eligible for the month in which you apply, your food stamp amount will be based on the date you actually turn in your application.

EXPEDITED SERVICE FOR FOOD STAMPS

Your household may qualify for Expedited Service and receive food stamps within 7 days if you are eligible and if your gross monthly income is less than $150 and liquid resources are $100 or less; or your monthly shelter bills are higher than your household's gross monthly income plus your liquid resources; or your household is a migrant or seasonal farm worker household with little or no income and resources. **GIVE THE INFORMATION BELOW SO YOUR ELIGIBILITY FOR EXPEDITED SERVICE CAN BE DETERMINED.**

Total money expected this month before deductions	$_____
Total cash, money in checking/savings accounts, CDs	$_____
Total rent or mortgage for this month	$_____
Total utility expenses for this month Do no count amounts due for previous months. Count only the basic telephone service cost.	$_____
Is anyone in your household a migrant or seasonal farm worker	YES ( ) NO ( )

NAME	DATE OF BIRTH
ADDRESS	SOCIAL SECURITY NUMBER
	TELEPHONE
SIGNATURE	DATE

AGENCY USE ONLY

CASE NAME		
CASE NUMBER		
LOCALITY	WORKER	DATE

EXPEDITED SERVICE DETERMINATION

Income less than $150 and Resources $100 or less — **YES ( ) NO ( )**

Income plus resources less than shelter bills — **YES ( ) NO ( )**

For migrants or seasonal farm workers:

Resources $100 or less, and in next 10 days $25 or less is expected from new income:

OR

Resources $100 or less, and no income is expected from a terminated source for the rest of this month or next month. — **YES ( ) NO ( )**

EXPEDITE IF YES TO ANY OF THE ABOVE.

COMPLETE AND ACCURATE INFORMATION

You must give complete, accurate, and truthful information. If you refuse to give needed information, your eligibility for assistance may not be able to be determined. Information regarding your race is not required. However, if you decided not to give this information, your worker will complete that section. If you knowingly give false, incorrect or incomplete information, or fail to report changes, you could lose your benefits and be arrested, prosecuted, fined and/or imprisoned. If you knowingly give false, incorrect, or incomplete information in order to help someone else receive benefits, you could be arrested and prosecuted for fraud.

VIRGINIA SOCIAL SERVICES BENEFIT PROGRAMS BOOKLET

This booklet contains information about the programs available at your local social services agency plus other very important information you should know, including your responsibilities. READ THIS BOOKLET CAREFULLY. Refer to the APPEALS Section if you have a complaint about an action taken on your case.

COMPLETING THE APPLICATION

If you need help completing this Application, a friend or relative or your eligibility worker can help you. If you are completing this application for someone else, answer each question as if you were that person. If you need to change an answer or make a correction, write the correct information nearby and put your initials and date next to the change. If more than 8 people are living in your home and you need more space to list everyone, tell the agency you need extra pages. If you want Medicaid and you are under 18 years of age, your parent or legal guardian must sign the application.

FILING THE APPLICATION

You may turn in a partially completed Application which contains at least your name, address, and signature (or the signature of your authorized representative), **but you must complete the rest of this Application before your eligibility can be determined.** For some programs, you must also be interviewed, but you may turn in your Application before your interview. You may turn in your Application any time during office hours the same day as you contact your local agency. You have the right to turn in your Application even if it looks like you may not be eligible for benefits.

YOUR FOOD STAMP RIGHTS

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs and disability.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue SW, Washington D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

APPLICATION FOR BENEFITS

AGENCY USE ONLY				
CASE NAME	CASE NUMBER	PROGRAM	WORKER CASELOAD	DATE REC'D.
DATE OF SERVICE REFERRAL	DATE OF INTERVIEW	LOCALITY		

1. I am requesting: ( ) Food Stamps ( ) TANF ( ) Medicaid/FAMIS Plus/FAMIS ( ) Other Financial or Medical Assistance
( ) I understand that an application for TANF is also an application for Food Stamps and I do not wish to apply for Food Stamps.

APPLICANT'S NAME	SOCIAL SECURITY NUMBER	PHONE NUMBER (HOME/MESSAGES) (WORK)
RESIDENCE ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)		DIRECTIONS TO HOME
MAILING ADDRESS (IF DIFFERENT)		

LANGUAGE (Enter Code) _____

1 - English 2 - Spanish 3 - Cambodian 4 - Vietnamese 5 - Farsi 6 - Haitian-Creole 7 - Laotian 8 - Chinese 9 - Korean A - Somali B - Kurdish C. - Arabic
F - French G - German J - Japanese O - Other

YES ( ) NO ( ) A. Does anyone have an emergency medical need? If **YES**, give name and explain_____

YES ( ) NO ( ) B. Is the applicant living in an Assisted Living Facility, an Adult Family Care Home, a Nursing Facility, or other institution?
If **YES**, Date Applicant Entered_____ City\County and State Applicant lived before entering _____
If outside Virginia, was placement made by a government agency? **YES ( ) NO ( )**

YES ( ) NO ( ) C. ANSWER THIS QUESTION IF APPLYING FOR MEDICAID, GENERAL RELIEF OR AUXILIARY GRANTS: Does this applicant have a spouse who does not live in the home?
If **YES**, Spouse's Name _____ Spouse's Address_____

2. **YES ( ) NO ( )** Have you or anyone for whom you are applying ever applied for, or received, or are currently receiving any benefits from a social services agency, including Food Stamps, AFDC, TANF, Medicaid, General Relief, Auxiliary Grants, Foster Care, Adoption Assistance, or Refugee Cash Assistance?

APPLICANT'S NAME	SOCIAL SECURITY NUMBER	TYPE OF BENEFITS RECEIVED
WHEN	FROM WHAT COUNTY OR CITY OR STATE	

3. **YES ( ) NO ( )** Have you or anyone for whom you are applying ever been convicted of making false or misleading statements about your identity or address to receive TANF, Food Stamps, or Medicaid in two or more states at the same time? If **YES**, give date and place of conviction_____

4. **YES ( ) NO ( )** Are you or anyone for whom you are applying in violation of parole or probation or fleeing capture to avoid prosecution or punishment of a felony?
If **YES,** explain_____

5. **YES ( ) NO ( )** Have you or anyone for whom you are applying been convicted of a felony for actions that occurred after August 22, 1996, for possession, use or distribution of drugs? If **YES,** explain_____

6. **YES ( ) NO ( )** Is there anything that you would like to talk about with a service worker? This could include concerns about your children, school problems, day care needs, family planning, referrals to other community organizations, or other problems or concerns. If **YES,** explain_____

INSTRUCTIONS

1. Do not write in the shaded areas. These areas are for agency use only.

2. Unfold this page. Use this folded page to complete **SECTION A: GENERAL INFORMATION.** Answer the questions in **SECTION A** for everyone who lives in your home, even if you are not applying for that person. You may leave questions about citizenship, immigration and Social Security Number blank for anyone for whom you are NOT requesting assistance.

3. Answer the questions in **SECTION B: RESOURCES,** unless you are applying for FAMIS Plus/FAMIS, for everyone for whom you are applying. In addition, if applying for **TANF or Medicaid** also provide resource information for the following persons:

   TANF: Children age 18 or under, even if you are not applying for that child.

   Medicaid: Spouse and children under age 21 who live with a person for whom you are applying.
   Parents who live with a child under age 21.
   Spouse of a person in a nursing facility, state hospital, or community-based care. Provide the spouse's shelter bills to your worker.

4. Answer the questions in **SECTION C: INCOME** for everyone for whom you are applying. In addition, if applying for **TANF or Medicaid or FAMIS Plus or FAMIS** also provide income information for the following persons:

   TANF: Children age 18 or under, even if you are not applying for that child.

   Medicaid: Spouse and children under age 21 who live with a person for whom you are applying.
   Spouse of a person in a nursing facility, state hospital, or community-based care. Provide the spouse's shelter bills to your worker.

   FAMIS Plus/FAMIS Parents and stepparents who live with a child under age 21.

5. After completing Sections A, B, and C, answer the questions in the sections indicated below, depending on the type of assistance you are requesting.

Food Stamps	**Section D** pp. 8-9
TANF/Medicaid	**Section E** p. 10
Refugee Resettlement Program	**Section E** p. 10 **only** for children age 18 and under
FAMIS Plus/FAMIS	**Section F** p. 11
Medicaid/Auxiliary Grants/General Relief	**Section G** p. 11
General Relief	**Section E** p. 10 **only** for children under age 18 **Sections I & J** p. 12
State and Local Hospitalization	**Section H** p. 12
Emergency Assistance	**Section J.** p. 12
Auxiliary Grants	**Section K** p. 12

6. Read **YOUR RESPONSIBILITIES** on page 13.

7. Read and complete **VOTER REGISTRATION** on page 13 of this application.

8. Read and complete the last page of this application. Be sure to sign and date the application.

A. GENERAL INFORMATION (ALL APPLICANTS MUST COMPLETE THIS SECTION)

1. EVERYONE IN YOUR HOME **LIST EVERYONE LIVING IN YOUR HOME**, even if you are not applying for assistance for that person. **LIST YOURSELF ON LINE #1.** Check (√) **YES ( ) NO ( )** Do you expect any change in who lives in your home, either this month or next month? If YES, explain: _____ LAST NAME, FIRST, MI, AND MAIDEN (DO NOT make any entry in the ID# space)		2. TEMPORARILY AWAY FROM HOME Is this person temporarily away from home? Check (√) **YES** or **NO** If **YES**, give the date the person left and expected return date If more than 45 days, give the reason for the absence.	3. RELATIONSHIP TO PERSON ON LINE #1 Give the relationship of each person to the person listed on Line #1.	4. TYPE OF ASSISTANCE REQUESTED Check (√) type of assistance requested for each person. If no assistance is requested, check **NONE** for that person.								
				FOOD STAMPS	TANF	MEDICAID/FAMIS Plus/FAMIS	GENERAL RELIEF	EMERGENCY ASSISTANCE	STATE & LOCAL HOSPITALIZATION	AUXILIARY GRANTS	REFUGEE RESETTLEMENT PROGRAM	NONE
1	ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason										
2	ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason										
3	ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason										
4	ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason										
5	ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason										
6	ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason										
7	ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason										
8	ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason										

Determine reason person is away.
Determine if any parents or spouses live in the home.
Determine if person under 18 are under parental control.
Determine if anyone is a payee for anyone else.

Determine living arrangement, such as subsidized housing for elderly, hospital, incarceration, etc.
If person is in ALF nursing facility, state hospital, or CBC, determine if a spouse, dependent, child, or dependent relative is in the home.
Determine living arrangement of the minor parent.

USE THE FOLDOUT TO COMPLETE THIS SECTION

5. U.S. CITIZEN Check (√) YES or NO If YES, do not answer Question 6. You may leave this blank for anyone not in the assistance request	6. ANSWER ONLY IF AN ALIEN Give the **Alien Number** and **Date of Entry** for anyone for whom you are requesting assistance. You may leave this blank for anyone not in the assistance request.	7. PLACE OF BIRTH Give the **State** if born in the U.S. or the **Country** if born outside of the U.S. 8. DATE OF BIRTH	9a. RACE (not required) Give the code **from the list at the bottom of the page** to show Race.	9b. ETHNICITY (not required) Give the **code** to show Ethnicity. 1 - Hispanic or Latino 2 - Not Hispanic or Latino	10. SEX Give the **code** to show Sex. M - Male F - Female	11. SOCIAL SECURITY NUMBER Give the number for anyone for whom you are requesting assistance.	12. MARITAL STATUS Give the **code** to show Marital status. 1 - Married 2 - Never Married 3 - Divorced 4 - Widowed 5 - Separated	13. VETERAN OR DEPENDENT OF A VETERAN Check (√) YES or NO
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )

Race Code List: 1 - White 2 - Black/African-American 3 - American Indian/Alaskan Native 4 - Asian 5 - Native Hawaiian/Other Pacific Islander 6 - American Indian/Alaskan Native and White 7 - Asian and White 8 - Black/African-American and White 9 - American Indian/Alaskan Native and Black/African-American A - Asian and Black B - Other

For Aliens, photocopy INS document. Inquire if requesting emergency care. Determine if sponsored. Obtain sponsor's name address, income, and resources.
For Asylees, verify date asylum was granted.
For Veterans, make referral to V.A.
For Medical Expenses, determine retroactive Medicaid entitlement.

USE THE FOLDOUT TO COMPLETE THIS SECTION

14. MEDICAL EXPENSES DURING THE 3 MONTHS BEFORE THIS MONTH. Check (√) **YES or NO** **If YES, give the Date of the Expense.**	**15. EDUCATION** Give the **Last Grade Completed** in school. Check (√) **YES or NO** Is the person a High School (HS) or GED graduate? Check (√) **YES or NO** Is the person **Currently Enrolled** in school? If YES, give the **school name** and use one of the **codes** to show enrollment. FT - Enrolled full time HT - Enrolled half time LT - Enrolled less than half time	SCHOOL NAME	ENROLLMENT CODE	**16. DISABILITY/ PREGNANT STATUS** Give the **code** to show Disability/Pregnant Status ND - Not disabled DS - Disabled BL - Blind CD - Needed to care for disabled person PG - Pregnant	**17. ANSWER ONLY IF DISABLED** A. Check (√) if the disability reduces or prevents the ability to work or to obtain work. B. Check (√) if the disability reduces or prevents the ability to care for a child in the home. C. Check (√) if the disability requires someone to be in the home to provide care.	**18. ANSWER ONLY IF PREGNANT AND APPLYING FOR MEDICAID** Give the **Conception** month and year and the **Expected Delivery Date**, and the number of **Unborn Children**.
YES ( ) NO ( ) Date	**A. Last Grade Completed: __________** **B. ( ) YES ( ) NO HS or GED Graduate** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**
YES ( ) NO ( ) Date	**A. Last Grade Completed: __________** **B. ( ) YES ( ) NO HS or GED Graduate** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**
YES ( ) NO ( ) Date	**A. Last Grade Completed: __________** **B. ( ) YES ( ) NO HS or GED Graduate** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**
YES ( ) NO ( ) Date	**A. Last Grade Completed: __________** **B. ( ) YES ( ) NO HS or GED Graduate** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**
YES ( ) NO ( ) Date	**A. Last Grade Completed: __________** **B. ( ) YES ( ) NO HS or GED Graduate** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**
YES ( ) NO ( ) Date	**A. Last Grade Completed: __________** **B. ( ) YES ( ) NO HS or GED Graduate** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**
YES ( ) NO ( ) Date	**A. Last Grade Completed: __________** **B. ( ) YES ( ) NO HS or GED Graduate** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**
YES ( ) NO ( ) Date	**A. Last Grade Completed: __________** **B. ( ) YES ( ) NO HS or GED Graduate** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**

B. RESOURCES

Answer the resource questions for everyone for whom you are applying unless you are applying for FAMIS Plus or FAMIS. If applying for **TANF or Medicaid**, also provide resource information for the additional persons indicated on the INSTRUCTIONS page. Include any resources anyone owns, is currently buying, or is heir to. Include any resources jointly owned with someone else, even if that person does not live with you. List the names of all joint owners. After each joint owner's name, list the percentage (%) of the resource owned by that person. TALK TO YOUR ELIGIBILITY WORKER IF YOU NEED HELP ANSWERING THESE QUESTIONS, INCLUDING THE PERCENTAGE OWNED.

YES ( ) NO ( ) 1. Cash on hand and not in a bank? If **YES**, list owner(s)_____ Amount_____

YES ( ) NO ( ) 2. Checking account, savings or investment account, credit union account, Christmas Club account, CDs or money market account, individual development account, patient funds for people in a nursing facility or Assisted Living Facility, or special welfare fund account? List all accounts, even if there is no money in the account. If **Yes** to savings or investment account, has the savings account been set up to pay for school expenses, to make a down payment on a house, or to start a business? Check (√) **YES ( ) NO ( )** If the savings account is to pay for school expenses, list the person(s) whose expenses will be paid _____.If the savings or investment account is for another purpose, explain _____

OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	YES ( ) NO ( ) Is this resource used in your business or trade, including farming?	AMOUNT $	DATE ACQUIRED
OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	YES ( ) NO ( ) Is this resource used in your business or trade, including farming?	AMOUNT $	DATE ACQUIRED
OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	YES ( ) NO ( ) Is this resource used in your business or trade, including farming?	AMOUNT $	DATE ACQUIRED

YES ( ) NO ( ) 3. Stocks or bonds, trust funds, pension plans, retirement accounts, promissory notes, or deeds of trust?

OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	AMOUNT $	DATE ACQUIRED
OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	AMOUNT $	DATE ACQUIRED

YES ( ) NO ( ) 4. Burial plots, burial arrangement or trust funds for burial?

OWNER(S)	NUMBER OF PLOTS, TYPE OF ARRANGEMENT	WHERE	VALUE $ AMOUNT OWED $	DATE ACQUIRED
OWNER(S)	NUMBER OF PLOTS, TYPE OF ARRANGEMENT	WHERE	VALUE $ AMOUNT OWED $	DATE ACQUIRED

YES ( ) NO ( ) 5. Personal property, such as campers/trailers, non-motorized boats, utility trailers, tools, equipment, supplies, or livestock?

OWNER(S)	TYPE	YES ( ) NO ( ) Is this property necessary to your business or trade, including farming?	VALUE $ AMOUNT OWED $	DATE ACQUIRED

YES ( ) NO ( ) 6. Real property, including life estates, land, buildings, or mobile homes? If **YES**, do you live there? Check (√) **YES ( ) NO ( )**

OWNER(S)	TYPE (INCLUDE NUMBER OF ACRES)	YES ( ) NO ( ) Currently rented YES ( ) NO ( ) Income producing YES ( ) NO ( ) Currently for sale	VALUE $ AMOUNT OWED $	DATE ACQUIRED

YES ( ) NO ( ) 7. Licensed or unlicensed vehicles, such as cars, trucks, vans, motorboats, motor homes, mobile homes, recreational vehicles, or motorcycles/mopeds?

OWNERS	TYPE OF VEHICLE: YEAR-MAKE-MODEL VEHICLE ID#	CURRENTLY LICENSED? YES ( ) NO ( )	LICENSE #	VALUE $ AMOUNT OWED $	EXPLAIN HOW VEHICLE IS USED	DATE ACQUIRED
OWNERS	TYPE OF VEHICLE: YEAR-MAKE-MODEL VEHICLE ID#	CURRENTLY LICENSED? YES ( ) NO ( )	LICENSE #	VALUE $ AMOUNT OWED $	EXPLAIN HOW VEHICLE IS USED	DATE ACQUIRED

YES ( ) NO ( ) 8. Health insurance?

POLICY HOLDER	COMPANY NAME, ADDRESS, PHONE	BEGIN DATE END DATE	ID NUMBER PREMIUM AMOUNT $	TYPE OF COVERAGE	PERSON(S) INSURED
POLICY HOLDER	COMPANY NAME, ADDRESS, PHONE	BEGIN DATE END DATE	ID NUMBER PREMIUM AMOUNT $	TYPE OF COVERAGE	PERSON(S) INSURED

YES ( ) NO ( ) 9. Medicare?

PERSON INSURED	CLAIM NUMBER	CHECK (√) ( ) PART A ( ) PART B	BEGIN DATE END DATE	PREMIUM	PAYMENT METHOD
PERSON INSURED	CLAIM NUMBER	CHECK (√) ( ) PART A ( ) PART B	BEGIN DATE END DATE	PREMIUM	PAYMENT METHOD

YES ( ) NO ( ) 10. Life insurance policies? **(NOT REQUIRED IF YOU ARE APPLYING ONLY FOR FOOD STAMPS)**

OWNER(S)	PERSON(S) INSURED	COMPANY NAME, ADDRESS, PHONE	TYPE OF POLICY	POLICY NUMBER	FACE VALUE $	CASH VALUE $	DATE ACQUIRED
OWNER(S)	PERSON(S) INSURED	COMPANY NAME, ADDRESS, PHONE	TYPE OF POLICY	POLICY NUMBER	FACE VALUE $	CASH VALUE $	DATE ACQUIRED

YES ( ) NO ( ) 11. Has anyone sold, transferred, or given away any resources in the last 3 months if applying for Food Stamps? In the last 2 years, if applying for **TANF** or **General Relief**? Any resources or income in the last 5 years if applying for **Medicaid**?

PROPERTY TRANSFERRED		VALUE AT TRANSFER $	AMOUNT RECEIVED $	EXPLAIN REASON FOR TRANSFER
FROM WHOM	TO WHOM	DATE ACQUIRED	DATE TRANSFERRED	

YES ( ) NO ( ) 12A. Does anyone expect to receive any money because of a legal suit involving personal injury or property damage? If **YES**, explain.
YES ( ) NO ( ) 12B. Does anyone expect a change in resources this month or next month? If **YES**, explain and give date change is expected.

EXPLAIN

C. INCOME (ALL APPLICANTS MUST COMPLETE THIS SECTION)

Answer the income questions for everyone for whom you are applying. If applying for **TANF** or **Medicaid**, also provide income information for the additional persons indicated on the INSTRUCTIONS page. And for **TANF** and for **Medicaid/FAMIS Plus/FAMIS** for children, also provide income information for the child's parent or stepparent living in the home; or any person living with the parent as husband or wife. If the parent is a minor under age 18 (for **TANF**) or under age 21 (for **Medicaid**), also provide income information for the parent of the minor parent.

1. Does anyone receive any of the following types of money from working? Check (√) **YES or NO** for each type. If **YES**, give the information requested.

YES ( ) NO ( ) Wages/salary
YES ( ) NO ( ) Contract income
YES ( ) NO ( ) Commissions, bonuses, tips
YES ( ) NO ( ) Vacation Pay
YES ( ) NO ( ) Earned sick pay
YES ( ) NO ( ) Babysitting/day care
YES ( ) NO ( ) Farming/fishing
YES ( ) NO ( ) Domestic work
YES ( ) NO ( ) Odd jobs
YES ( ) NO ( ) Other self employment
YES ( ) NO ( ) Any other money from working

PERSON RECEIVING MONEY FROM WORKING	EMPLOYER'S NAME, ADDRESS, PHONE NUMBER	EMPLOYMENT BEGIN DATE	HOURS WORKED PER MONTH	RATE OF PAY	HOW OFTEN PAID	DAY OF THE WEEK PAID	GROSS MONTHLY PAY BEFORE DEDUCTIONS
				$ PER			$
				$ PER			$
				$ PER			$

2. Does anyone receive any other type of money? Check (√) **YES OR NO** for each type. If **YES**, give the information requested.

YES ( ) NO ( ) Social Security
YES ( ) NO ( ) SSI
YES ( ) NO ( ) VA benefits
YES ( ) NO ( ) Black Lung benefits
YES ( ) NO ( ) Railroad Retirement
YES ( ) NO ( ) Other retirement
YES ( ) NO ( ) Child support, alimony
YES ( ) NO ( ) Military Allotment
YES ( ) NO ( ) Unemployment benefits
YES ( ) NO ( ) Worker compensation
YES ( ) NO ( ) Strike benefits
YES ( ) NO ( ) Interest, dividends
YES ( ) NO ( ) Cash gifts or contributions
YES ( ) NO ( ) Public Assistance
YES ( ) NO ( ) Room/board income
YES ( ) NO ( ) Rental Income
YES ( ) NO ( ) Prize winnings
YES ( ) NO ( ) Insurance settlement
YES ( ) NO ( ) Loans
YES ( ) NO ( ) Training allowances including WIA
YES ( ) NO ( ) Inheritance
YES ( ) NO ( ) All food, clothing, utilities, or rent
YES ( ) NO ( ) Any other type of money

PERSON RECEIVING MONEY	TYPE OF MONEY RECEIVED	HOW OFTEN RECEIVED	WHEN RECEIVED	GROSS MONTHLY AMOUNT BEFORE DEDUCTIONS
				$
				$
				$
				$

For Self Employment Income, determine expenses.
For Day Care Income, determine whether child lives in the home, number of snacks or meals, expenses.
For Roomer/Boarder Income, determine whether heat is provided, number of meals provided per day.
For Rental Income, determine whether properly is actively self-managed, expenses.
For Earned Income, determine whether earnings include EITC advance payments.
Inquire if SSI has been applied for.

For Food Stamps, investigate voluntary quit/work reduction.
For TANF, determine the day care option.
For Medicaid, determine income of spouse, dependent child, or dependent relative of person in nursing facility, state hospital, or CBC.

YES ( ) NO ( ) 3. Has anyone been fired, laid off, gone on sick or maternity leave, gone on strike, quit a job or reduced hours worked in the last 60 days?

NAME OF PERSON	EMPLOYER'S NAME, ADDRESS PHONE	EMPLOYED FROM/TO	HRS./WK. WORKED	RATE OF PAY	HOW OFTEN PAID	DATE LAST PAY RECEIVED	REASON FOR LEAVING, REDUCING HOURS
				$ PER			

YES ( ) NO ( ) 4. Does anyone besides the people for whom you are applying pay directly for you, help you pay, or lend you money to pay rent, utilities, medical bills or any other bills? Or, does anyone totally provide food or clothing for you or someone else on a regular basis?

PERSON RECEIVING HELP	PERSON PROVIDING HELP	TYPE OF HELP RECEIVED	AMOUNT	DOES MONEY COME DIRECTLY TO YOU?	IS THIS A LOAN?	IS REPAYMENT EXPECTED
			$ PER	YES ( ) NO ( )	YES ( ) NO ( )	YES ( ) NO ( )
			$ PER	YES ( ) NO ( )	YES ( ) NO ( )	YES ( ) NO ( )

YES ( ) NO ( ) 5. Has anyone applied for or received student financial aid or work-study for a current school term at a college or university? Or, any school or training program beyond the high school level? Or, any school or training program for the physically or mentally disabled?

				SCHOOL EXPENSES					
NAME OF PERSON	TYPE OF FINANCIAL AID	AMOUNT	PERIOD COVERED	TUITION FEES	BOOKS/ SUPPLIES	TRANSPOR-TATION	DEPENDENT CARE	ROOM & BOARD	OTHER (specify)
		$	FROM TO	$	$	$	$	$	$
		$	FROM TO	$	$	$	$	$	$

YES ( ) NO ( ) 6. Does anyone expect any change in the type of money received, employment, or hours worked, either this month or next month?

If **YES**, explain and give date: _____

YES ( ) NO ( ) 7. Does anyone have a day care expense for a child, an elderly person, or an adult with a disability?

PERSON PAYING FOR CARE	PERSON RECEIVING CARE	CHECK (√) IF DISABLED	PROVIDER'S NAME, ADDRESS, PHONE NUMBER	AMOUNT PAID
		( ) Disabled		$ PER
		( ) Disabled		$ PER

YES ( ) NO ( ) 8. Does anyone pay legally obligated child support to someone not in the household? If **YES,** person paying: _____

Person supported: _____ Amount paid and how often: _____

YES ( ) NO ( ) 9. **ANSWER ONLY IF SOMEONE IS APPLYING FOR MEDICAID AND IS BLIND OR DISABLED:** Does this person have a work related expense?

If **YES,** give amount and explain: _____

D. FOOD STAMPS

1. List the name of the person who is the head of your household: _____.

NOTE: Refer to the Benefit Programs Booklet for information about naming the Head of Household.

YES ( ) NO ( ) 2. Would you like to name an authorized representative who could apply for food stamps for you, access your food stamp account to buy food for you, or receive food stamp correspondence and notices for you? You may have only one representative who can access your benefits.

NAME, ADDRESS, PHONE NUMBER OF AUTHORIZED REPRESENTATIVE(S)		CHECK (√) EACH DUTY AUTHORIZED FOR THAT PERSON
1		( ) Apply for food stamps ( ) Receive correspondence ( ) Receive food stamps
2		( ) Apply for food stamps ( ) Receive correspondence ( ) Receive food stamps

An authorized representative must have written permission to apply for food stamps. This permission may be given in the space above or in a letter. Only the head of the household, the spouse, or any adult member of the household age 18 or older may give permission for a representative.

YES ( ) NO ( ) 3. Is anyone living in your home NOT included on your Food Stamp application?

If **YES**, do you and everyone for whom you are applying usually purchase and prepare meals apart from these people? Or, do you intend to do so if your application for Food Stamps is approved? Check (√) **YES ( ) NO ( ) IF YES**, list names: _____

YES ( ) NO ( ) 4. Is anyone living in your home a roomer or a boarder? If **YES**, list names: _____

YES ( ) NO ( ) 5. Is anyone age 60 or older, **OR** approved to receive Medicaid because of a disability, **OR** receiving any type of disability check?

If **YES**, list all current medical expenses for these people, including Medicare premiums, other medical insurance premiums, medical and dental bills, psychotherapy, prescription drugs, eye glasses, dentures, hearing aids, transportation for medical services, nursing services, and any other medical bills. ALSO, indicate how you would like these medical expenses deducted in order to determine your food stamp benefits. TALK TO YOUR WORKER BEFORE ANSWERING METHOD OF DEDUCTION.

PERSON WITH EXPENSE	TYPE OF EXPENSE	AMOUNT	NAME, ADDRESS, PHONE NUMBER OF DOCTOR, HOSPITAL, PHARMACY	METHOD OF DEDUCTION
		$		( ) Lump sum ( ) Monthly average ( ) Expected payment
		$		( ) Lump sum ( ) Monthly average ( ) Expected payment
		$		( ) Lump sum ( ) Monthly average ( ) Expected payment

YES ( ) NO ( ) 6. Does anyone have any shelter expenses for rent or mortgage, real estate tax, property tax on a mobile home, home owner's insurance, electricity, gas, kerosene, coal, oil, wood, water or sewer, telephone, or initial installation fee for utilities or telephone? If **YES,** answer questions a, b, and c. Then, give the information requested in boxes.

a. **YES ( ) NO ( )** Are any utilities included in your rent? If **Yes**, leave the boxes for those expenses blank.

b. **YES ( ) NO ( )** Are taxes or insurance included in your mortgage payment? If **Yes,** leave those boxes blank.

c. **YES ( ) NO ( )** Do you have an expense for telephone services? If **Yes**, does anyone living in your home but not included on your Food Stamp application help you pay your telephone bill? Check (√) **YES ( )** or **NO ( )**

If **YES**, explain: _____

EXPENSE	Rent or Mortgage	Taxes	Insurance	Electricity	Gas	Kerosene	Coal	Oil	Wood	Water/Sewer	Garbage	Installation
AMOUNT BILLED	$	$	$	$	$	$	$	$	$	$	$	$
HOW OFTEN												
WHO PAYS BILL												

YES ( ) NO ( ) 7. Does anyone have or expect to have an expense for heating or cooling the home? Or, has anyone received assistance from the Fuel Assistance Program during this past year?

If **YES**, check (√) whether you would like your food stamp benefits determined using your actual utility expenses or a standard amount we use for these expenses. TALK TO YOUR WORKER BEFORE ANSWERING. **Actual Utility Expenses ( ) Utility Standard ( )**

If the **Utility Standard** is selected, does anyone living in your home but not included on your Food Stamp application help you pay your heating or cooling bill? Check (√) **YES ( ) NO ( )** If **YES,** explain: _____

YES ( ) NO ( ) 8. Are you staying temporarily in someone else's home, an emergency shelter, welfare hotel, other halfway house, or a place not usually used for sleeping? If temporarily staying in someone else's home, give the date you moved in: _____

If **YES,** check (√) whether you would like your food stamp benefits determined using your actual shelter expenses or a standard amount we use for these expenses. TALK TO YOUR WORKER BEFORE ANSWERING. **Actual Shelter Expenses ( ) Homeless Shelter Allowance ( )**

YES ( ) NO ( ) 9. Does anyone have a shelter expense for a home (rented or owned) that is temporarily not lived in because of employment or training away from home, illness, or a disaster?

REASON FOR NOT LIVING THERE	DOES PERSON INTEND TO RETURN?	TYPE AND AMOUNT OF SHELTER EXPENSES	IS SOMEONE ELSE LIVING THERE?	IF SOMEONE ELSE LIVES THERE, DOES THAT PERSON PAY RENT?
	YES ( ) NO ( )		YES ( ) NO ( )	YES ( ) NO ( )

(ASK FOR AN EXTRA PAGE IF YOU NEED MORE SPACE)

E. FINANCIAL AND MEDICAL ASSISTANCE FOR FAMILIES WITH CHILDREN

ANSWER QUESTIONS 4, 5 AND 6 **ONLY** IF ANSWER TO QUESTION 3 IS **"SEPARATED, LIVING APART"** AND YOU ARE APPLYING FOR MEDICAID.

1. CHILD/PARENT INFORMATION List each child for whom you are applying. Then, list the names of both parents. YOU MUST IDENTIFY BOTH PARENTS IN ORDER TO RECEIVE TANF. IF YOU INTENTIONALLY MISIDENTIFY A PARENT, YOU SHALL BE PROSECUTED	**2. PARENT'S STATUS** Check if either PARENT is:				**3. REASONS FOR ABSENCE** **(Answer only if the answer to question 2 is "absent" and you are applying for Medicaid.)** **For each ABSENT PARENT, check reason for absence.**									**4. FINANCIAL SUPPORT** Does the ABSENT PARENT regularly provide monthly financial support? Check (√) **YES** or **NO** If **YES**, give amount, and how often received.	**5. PHYSICAL CARE** Does the ABSENT Parent regularly make sure the child eats, sleeps, bathes, dresses properly, and gets proper medical care? Check (√) **YES** or **NO**	**6. GUIDANCE** Does the ABSENT PARENT regularly particpate in the child's activities, attend school conferences, and share in decisions about discipline? Check (√) **YES** or **NO**	**7. IMMUNIZATION** **(Answer only if applying forTANF and the child is not in school.)** Has the child received **ALL** of the immunizations required according to the child's age? Check (√) **YES** or **NO** or **UNKNOWN**
	UNEMPLOYED	DISABLED	DEAD	ABSENT	PATERNITY NOT ESTABLISHED	DIVORCED OR MARRIAGE ANNULLED	INCAPACITATED	DESERTED	SEPARATED LIVING APART	SENTENCED BY COURT TO DO UNPAID WORK	DEPORTED	ARTIFICIAL INSEMINATION	SINGLE PARENT ADOPTION				
CHILD'S NAME																	YES ( ) NO ( ) UNKNOWN ( )
MOTHER														YES ( ) NO ( ) $ PER	YES ( ) NO (	YES ( ) NO ( )	
FATHER														YES ( ) NO ( ) $ PER	YES ( ) NO ( )	YES ( ) NO ( )	
CHILD'S NAME																	YES ( ) NO ( ) UNKNOWN ( )
MOTHER														YES ( ) NO ( ) $ PER	YES ( ) NO ( )	YES ( ) NO ( )	
FATHER														YES ( ) NO ( ) $ PER	YES ( ) NO ( )	YES ( ) NO ( )	
CHILD'S NAME																	YES ( ) NO ( ) UNKNOWN ( )
MOTHER														YES ( ) NO ( ) $ PER	YES ( ) NO ( )	YES ( ) NO ( )	
FATHER														YES ( ) NO ( ) $ PER	YES ( ) NO ( )	YES ( ) NO ( )	
CHILD'S NAME																	YES ( ) NO ( ) UNKNOWN ( )
MOTHER														YES ( ) NO ( ) $ PER	YES ( ) NO ( )	YES ( ) NO ( )	
FATHER														YES ( ) NO ( ) $ PER	YES ( ) NO ( )	YES ( ) NO ( )	

F. FAMIS PLUS/FAMIS

YES ( ) NO ( ) 1. Did any of the children listed above have health insurance in the past 4 months? If yes, (a) list name of child, type of insurance, such as doctor, hospital, drugs, dental, vision, etc., and the date the insurance ended; and (b) select the reason the insurance ended.

Child: _____ Type of insurance: _____

Date ended _____

Reason insurance ended:

- ☐ The parent or stepparent changed jobs or stopped employment and no other employer contributes to the cost of family coverage.
- ☐ The parent or stepparent's employer stopped contributing to the cost of family coverage and no other employer contributes to the cost of family coverage.
- ☐ Child uninsurable—insurance company discontinued coverage. (Provide proof that coverage stopped by insurance company)
- ☐ Cost exceeded 10% of monthly income (before taxes). (Provide proof of cost of monthly premium)
- ☐ Stopped/dropped by someone other than parent or stepparent.
- ☐ Stopped/dropped Cobra policy
- ☐ Other _____

YES ( ) NO ( ) 2. Is any member of the family, including a stepparent who lives in the home, employed by a State or Local Government agency? If yes, list name of family member(s) and agency name: _____

YES ( ) NO ( ) 3. Does the employer of any member of the family offer health insurance for family members? If yes, list the names of the children listed on this application who can get insurance through the employer? _____

G. AGED, BLIND, OR DISABLED INDIVDUALS

YES ( ) NO ( ) 1. Have you ever applied for Supplemental Security Income (SSI) or social security as a disabled person? If **YES,** date applied: _____
Check one: ( ) No Decision Yet ( ) Application Approved ( ) Application Denied

YES ( ) NO ( ) 2. If your application was denied, did you file an appeal of the denial? If yes, explain the action taken by the Social Security Administration (SSA) on the appeal request? _____

YES ( ) NO ( ) 3. Has it been less than 12 months since your most recent application for Social Security or SSI disability benefits was denied? If yes, list the medical conditions that you asked SSA to evaluate. _____.

YES ( ) NO ( ) 4. Has your condition changed or worsened since your most recent application for Social Security or SSI disability benefits was denied. If yes, explain how your condition has changed or worsened. _____

YES ( ) NO ( ) 5. Do you have a new condition that has occurred since your most recent application for Social Security or SSI disability benefits was denied? If yes, explain the new condition. _____

YES ( ) NO ( ) 6. Did you receive an Auxiliary Grants check that has stopped? If yes, explain when and why the payments stopped. _____
_____

YES ( ) NO ( ) 7. Did you receive a SSI check that has stopped? If yes, explain when and why the payments stopped. _____
_____

H. STATE AND LOCAL HOSPITALIZATION

YES ( ) NO ( ) Have you received or will you be receiving in-patient/out-patient hospitalization services, or ambulatory surgical services, or services through a health department clinic? If **YES**, please fill out the following:

PERSON RECEIVING SERVICES	NAME OF HOSPITAL OR CLINIC	IF SERVICE HAS ALREADY BEEN RECEIVED, GIVE THE DATES BELOW DATE ADMITTED: DATE DISCHARGED:

If you were hospitalized as the result of an accident, complete the following:

WHAT HAPPENED, WHERE, HOW	NAME, ADDRESS OR PERSON AT FAULT	IS A LIABILITY SUIT PLANNED OR IN PROGRESS? YES ( ) NO ( )

NAME, ADDRESS OF ALL INSURANCE COMPANIES INVOLVED	NAME, ADDRESS, PHONE NUMBER OF YOUR ATTORNEY

I. GENERAL RELIEF

YES ( ) NO ( ) Does anyone have any responsibility for rent or utility bills (not telephone), even if someone else helps pays?

J. GENERAL RELIEF/EMERGENCY ASSISTANCE

YES ( ) NO ( ) Does anyone have any emergency food, rent, utility (not deposits), medical, clothing, transient or relocation expenses?

DESCRIPTION AND CAUSE OF EMERGENCY

K. AUXILIARY GRANTS

YES ( ) NO ( ) 1. Do you own any household goods or personal effects which are worth more than $500, such as silver, fine china, furs, artworks, expensive jewelry, or other expensive items?

DESCRIPTION AND VALUE OF ITEMS

YES ( ) NO ( ) 2. Do you owe or did you pay in the month of application any bills you had before you entered the assisted living facility or adult family care?

DESCRIPTION OF BILLS	DATES OF BILLS	DATES BILLS PAID

YOUR RESPONSIBILITIES (READ THIS SECTION CAREFULLY BEFORE SIGNING THIS APPLICATION)

CHANGES

You must report the following changes for the Medicaid/FAMIS Plus Programs within 10 days. You must report these changes for the Auxiliary Grants and General Relief Programs the day the change occurs or the first day that the agency is open after the change occurs. The following examples of changes may include some that do not have to be reported for every program. If you are not sure whether to report a particular change, please discuss the change with your worker.

1) Change of address and any changes in shelter costs due to the move
2) Change in the persons in the household – person left, person born, etc.
3) Change in source of income, getting a new job, stopping a job, other benefits, etc.
4) Change in work hours from part-time to full-time or full-time to part-time
5) Change in rate of pay per hour/day, etc.
6) Change in the amount of monthly income received other than from a job.
7) Change in resources
8) Change in motor vehicles owned
9) Change in marital status
10) Person in home is no longer disabled
11) Change in dependent care expenses
12) Other changes that may affect eligibility for a program or the amount of assistance

You must report the following changes for the Food Stamp and Temporary Assistance for Needy Families (TANF) Programs within 10 days.

1) Change in household income that exceeds 130% of the Federal poverty level. See the Change Report for amounts.
2) Change in address.
3) Changes needed for VIEW (TANF work program).
4) Change in work hours for some food stamp recipients.

PENALTIES FOR FOOD STAMP VIOLATIONS

You must not give false information or hide information to get food stamps. You must not trade or sell EBT cards. You must not use food stamp benefits to buy non-food items, such as alcohol, tobacco or paper products. You must not use someone else's EBT card for your household.

Anyone who intentionally breaks any of these rules could be barred from the Food Stamp Program for 12 months (1st violation), 24 months (2nd violation), or permanently (3rd violation); subject to $250,000 fine, imprisoned up to 20 years, or both; and suspended for an additional 18 months and further prosecuted under other Federal and State laws.

Anyone who intentionally gives false information or hides information about identity or residence to get food stamps in more than one locality at the same time could be barred for 10 years.

Anyone court convicted of trading or selling food stamps of $500.00 or more could be barred permanently.

Anyone court convicted of trading food stamps for a controlled substance could be barred for 24 months for the 1st violation, permanently for the 2nd violation.

Anyone court convicted of trading food stamps for firearms, ammunition, or explosives could be barred permanently for the first violation.

Anyone convicted of a drug-related felony for actions that occurred after August 22, 1996, could be barred permanently.

PENALTIES FOR TANF VIOLATIONS

You must not knowingly give false information, hide information, or fail to report changes on time in order to receive TANF or to receive supportive or transitional services such as child care or assistance with transportation.

If you are found guilty of intentionally breaking these rules, you will be ineligible to receive TANF for yourself for 6 months (1st violation), 12 months (2nd violation), or permanently (3rd violation). In addition, you may be prosecuted under Federal or State law.

Anyone convicted of misrepresenting his or her residence to get TANF, Medicaid, Food Stamps or SSI in two or more states is ineligible for TANF for 10 years.

Anyone convicted of a drug-related felonyfor actions that occurred after August 22, 1996, could be barred permanently.

INFORMATION ABOUT THE DIVISION OF CHILD SUPPORT ENFORCEMENT (DCSE)

In order to receive TANF, you are required to assign all of your rights to financial support paid to you and to everyone else for whom you are receiving TANF. You must give to DCSE any support payments you receive after you receive your first TANF check. By accepting the TANF check, you are agreeing to assign these rights.

VOTER REGISTRATION

Check one of the following:

( ) I am not registered to vote where I currently live now, and would you like to register to vote here today. I certify that a voter registration application form was given to me to complete. (If you would like help filling out the voter registration application form, we will help you. The decision to accept help is yours. You also have the right to complete your voter registration application form in private.)
( ) I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote.)
( ) I do not want to apply to register to vote today.
( ) I do want to apply to register to vote, please send me a voter registration form.

Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, you right to privacy in deciding whether to register to vote, or your right in applying to register to vote, you may file a complaint with: Secretary of the Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497, (804) 786-6551.

Agency Use Only: ☐ Face-to-face interview not required. A voter registration form was mailed.

BY MY SIGNATURE BELOW, I DECLARE:

- I understand all othe information in the GENERAL INFORMATION and the YOUR RESPONSIBILITIES sections of this application.
- I understand that if I refuse to cooperate with any review of my eligibility including review by Quality Control, my benefits may be denied until I cooperate.
- I understand that if my application is for Food Stamps, failure to report or verify any of my expenses will be seen as a statement by my household that I do not want to receive a deduction for unreported expenses.
- I understand that Medicaid, FAMIS, and DMAS contractors may exchange information relating to my child(ren)'s coverage with local educational agencies, to assist with application, enrollment, administration, and billing for services provided to my child in schools. I understand that I can revoke the consent to disclose information at any time.
- I understand that to receive benefits from the Medicaid/FAMIS Plus/FAMIS programs, I must agree to assign my rights and the rights of anyone for whom I am applying to medical support and other third-party payments to the Department of Medical Assistance Services. If I do not agree to assign my rights, I will be ineligible for Medicaid.
- I understand that all money I receive for diagnosis or treatment of any injury, disease, disability, or medical care support must be sent to the Third-Party Liability Section, Department of Medical Assistance Services, Suite 1300, 600 East Broad Street, Richmond, VA 23219.
- I understand that I have the right to file a complaint if I feel I have been discriminated against because of race, color, national origin, sex, age, handicap, or religious belief.
- I understand that if I am applying for Medicaid/FAMIS Plus/FAMIS for my children, I can apply for and receive services from the Division of Child Support Enforcement, but failure to apply for the services will not affect my child(ren)'s eligibility. If I am applying for Medicaid, failure to cooperate my cause my ineligibility for Medicaid.
- I understand that I have the right to appeal and have a fair hearing if I am: (1) not notified in writing of the decision regarding my application within specified time frames10 days; (2) denied benefits from the programs for which I applied; or (3) dissatisfied with any other decision that affects my receipt of Medicaid/FAMIS Plus. For FAMIS, there will be no opportunity for review of a negative action if the sole basis for the action is exhaustion of funding.
- I will report any changes in my situation within the time frames specified on page 13 to my local department of social services.
- I have given true and correct information on this application to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report a change promptly or on purpose, I may be breaking the law and could be prosecuted for perjury, larceny, and/or welfare fraud. I understand that if I help someone complete this form so as to get benefits he or she is not entitled to receive, I may be breaking the law and could be prosecuted
- I understand that my signature on this application certifies, under penalty of perjury, that I am (unless applying for emergency services only) a U.S. Citizen or alien in lawful immigration status.
- I authorize the Department of Social Services and the Department of Medical Assistance Services to obtain any verification necessary to both determine and review financial or medical assistance eligibility. This authorization includes the release of any medical or psychological information obtained from any source to any state or local agency that may review this application and the release to the Department of Medical Assistance Services of any information in any medical records pertaining to any services received by me or anyone for whom I applied. This authorization is valid for one year from the date of my signature below. I understand that this time limit does not apply to investigations regarding possible fraud.

I received the Benefit Programs Booklet **YES ( ) NO ( )**

TANF APPLICANTS: The diversionary assistance program was explained to me. **YES ( ) NO ( )**
The family cap provision was explained to me. **YES ( ) NO ( )**

I filled in this application myself. **YES ( ) NO ( )** If **NO**, it was read back to me when completed. **YES ( ) NO ( )**

APPLICANT'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK	DATE	SPOUSE'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK (NOT NEEDED FOR FOOD STAMPS)	DATE
WITNESS TO MARK OR INTERPRETER	DATE	WORKER'S SIGNATURE	DATE

Complete the box below if this application was completed for the applicant by someone else.

NAME OF PERSON COMPLETING APPLICATION	DATE	ADDRESS
PHONE NUMBER (HOME) (WORK)		REALATIONSHIP TO APPLICANT

APPLICATION FOR BENEFITS

FORM NUMBER - 032-03-824

PURPOSE OF FORM - To record a household's request for assistance and to provide information about the current situation needed to determine eligibility.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The application is to be completed by or on behalf of the applying household. The completed application may be mailed to the agency or completed at the agency prior to or during an interview. The completed application is to be filed in the eligibility case record. The application must be retained for a minimum of three years.

The application may be used to apply for benefits of other programs if assistance is requested within three months of the original filing date. The date of the application in this instance is the date of the secondary request.

INSTRUCTIONS FOR PREPARATION OF FORM - General instructions appear of the form for completion.

If changes need to be made after the application is completed, the applicant should write the revised information near the original entry. The applicant must initial and date the changes. Except for agency-use sections, eligibility workers may not add to or write on a completed application.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

APPLICATION/REDETERMINATION FOR MEDICAID FOR SSI RECIPIENTS

AGENCY USE ONLY		
CASE NAME		LOCALITY
CASE NUMBER	WORKER	DATE RECEIVED

A. IDENTIFYING INFORMATION

NAME: _____ RACE: _____ SEX: _____

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

MARITAL STATUS: NEVER MARRIED _____ MARRIED _____ SEPARATED _____ WIDOWED _____ DIVORCED _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ TELEPHONE NUMBER: _____

COUNTRY OF ORIGIN: _____ CITIZEN/ALIEN STATUS: _____

B. ADDITIONAL INFORMATION

CIRCLE ONE

1. I AM A RESIDENT OF VIRGINIA. YES NO

2. I RECEIVE A SUPPLEMENTAL SECURITY INCOME (SSI) CHECK. YES NO

3. I OWN, HAVE AN INTEREST IN, OR HAVE INHERITED REAL PROPERTY (LAND OR BUILDINGS). YES NO

   TYPE OF PROPERTY: _____ ACREAGE: _____

   VALUE: $ _____ LOCATION: _____

4. I HAVE OTHER RESOURCES SUCH AS LIVESTOCK, CAR, TRUCK, CAMPER, MOBILE HOME,RETIREMENT ACCCOUNT, LIFE INSURANCE, BANK ACCOUNT, STOCKS, BONDS, SAVINGS CERTIFICATES, PATIENT FUND ACCOUNT, TRUST FUNDS, CASH, BURIAL PLOTS, OR BURIAL ARRANGEMENTS. YES NO

   RESOURCE: _____ VALUE:_____

   RESOURCE: _____ VALUE:_____

   RESOURCE: _____ VALUE:_____

5. I HAVE SOLD, TRADED, OR GIVEN AWAY ASSETS (LAND, BUILDINGS, BANK ACCOUNTS, MONEY, CARS, STOCKS, TRUST FUNDS, INCOME, ETC.) DURING THE PREVIOUS 60 MONTHS. YES NO

   WHEN: _____ TO WHOM: _____

   WHAT: _____ AMOUNT RECEIVED: $ _____

6. I HAVE MEDICARE. YES NO

   MEDICARE #: _____

   PART A EFFECTIVE DATE: _____ PART B EFFECTIVE DATE: _____

7. I HAVE OTHER HEALTH INSURANCE. YES NO

   COMPANY NAME: _____ POLICY #: _____

   TYPE OF COVERAGE: _____ EFFECTIVE DATE: _____

8. I LIVE IN A NURSING FACILITY OR STATE INSTITUTION. YES NO

   IF YOU STILL OWN YOUR HOME, WHO LIVES IN IT. _____
   (NAME AND RELATIONSHIP)

10. I RECEIVED MEDICAL CARE DURING THE THREE MONTHS BEFORE THIS APPLICATION. YES NO

FROM: _____ DATE: _____

RIGHTS AND RESPONSIBILITIES

I UNDERSTAND THAT I MUST REPORT ANY CHANGES THAT OCCUR IN MY SITUATION TO THE DEPARTMENT OF SOCIAL SERVICES WITHIN TEN DAYS. I AGREE TO ASSIGN MY RIGHTS TO MEDICAL SUPPORT AND OTHER THIRD-PARTY PAYMENTS TO THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES, EFFECTIVE WITH MY COVERAGE UNDER MEDICAID. ALL MONEY I RECEIVE FOR (1) DIAGNOSIS OR TREATMENT OF ANY INJURY, DISEASE OR DISABILITY OR (2) MEDICAL CARE SUPPORT MUST BE SENT TO THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES, THIRD PARTY LIABILITY SECTION. I UNDERSTAND REFUSAL TO ASSIGN MY RIGHTS WILL MAKE ME INELIGIBLE FOR MEDICAID.

I UNDERSTAND THAT I HAVE THE RIGHT TO FILE A COMPLAINT IF I FEEL I HAVE BEEN DISCRIMINATED AGAINST BECAUSE OF RACE, COLOR, NATIONAL ORIGIN, SEX, AGE, HANDICAP, OR RELIGIOUS BELIEF. I UNDERSTAND THAT I HAVE THE RIGHT TO APPEAL AND HAVE A FAIR HEARING IF I AM (1) NOT NOTIFIED IN WRITING OF THE DECISION REGARDING MY APPLICATION WITHIN 45 DAYS; (2) DENIED MEDICAID; OR (3) DISSATISFIED WITH ANY OTHER DECISION THAT AFFECTS MY RECEIPT OF MEDICAID. I UNDERSTAND THAT REFUSAL TO COOPERATE WITH A REVIEW OF MY MEDICAID ELIGIBILITY BY QUALITY CONTROL WILL MAKE ME INELIGIBLE FOR MEDICAID UNTIL I COOPERATE WITH THE REVIEW.

I AUTHORIZE THE DEPARTMENT OF SOCIAL SERVICES AND THE DEPARTMENT OF MEDICAL ASSISTANCE TO OBTAIN ANY VERIFICATIONS NECESSARY TO ESTABLISH MY ELIGIBILITY FOR ASSISTANCE. I AUTHORIZE RELEASE TO THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES ANY INFORMATION IN ANY MEDICAL RECORDS PERTAINING TO ANY SERVICES RECEIVED BY ME AS A BENEFIT UNDER MY MEDICAL ASSISTANCE (MEDICAID) ELIGIBILITY.

I RECEIVED THE BOOKLETS: MEDICAID HANDBOOK [ ] YES [ ] NO BENEFIT PROGRAMS [ ] YES [ ] NO

I FILLED IN THIS FORM MYSELF. [ ] YES [ ] NO IF NO, IT WAS READ BACK TO ME WHEN COMPLETED. [ ] YES [ ] NO

I DECLARE THAT ALL INFORMATION I HAVE GIVEN ON THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT IF I GIVE FALSE INFORMATION, WITHHOLD INFORMATION, OR FAIL TO REPORT A CHANGE PROMPTLY OR ON PURPOSE, I MAY BE BREAKING THE LAW AND COULD BE PROSECUTED FOR PERJURY, LARCENY, AND/OR WELFARE FRAUD. I UNDERSTAND THAT MY SIGNATURE ON THIS APPLICATION CERTIFIES, UNDER PENALTY OF PERJURY, THAT I AM A U.S. CITIZEN OR ALIEN IN LAWFUL IMMIGRATION STATUS.

SIGNATURE OR MARK: _____ DATE: _____

WITNESS/AUTHORIZED REPRESENTATIVE: _____ DATE: _____

I COMPLETED THIS APPLICATION/REDETERMINATION FOR _____. I UNDERSTAND THAT IF I AIDED OR ABETTED THIS INDIVIDUAL IN OBTAINING ASSISTANCE FOR WHICH HE IS NOT ELIGIBLE, THAT I MAY BE BREAKING THE LAW AND COULD BE PROSECUTED.

SIGNATURE: _____ RELATIONSHIP: _____ DATE: _____

ADDRESS: _____ TELEPHONE#: _____

VOTER REGISTRATION
CHECK ONE OF THE FOLLOWING:

( ) I AM NOT REGISTERED TO VOTE WHERE I CURRENTLY LIVE NOW, AND I WOULD LIKE TO REGISTER TO VOTE HERE TODAY. I CERTIFY THAT A VOTER REGISTRATION FORM WAS GIVEN TO ME TO COMPLETE. (IF YOU WOULD LIKE HELP IN FILLING OUT THE VOTER REGISTRATION, WE WILL HELP YOU. THE DECISION TO HELP YOU IS YOURS. YOU ALSO HAVE THE RIGHT TO COMPLETE YOUR FORM IN PRIVATE.)

( ) I AM REGISTERED TO VOTE AT MY CURRENT ADDRESS. (IF ALREADY REGISTERED AT YOUR CURRENT ADDRESS, YOU ARE NOT ELIGIBLE TO REGISTER TO VOTE.)

( ) I DO NOT WANT TO APPLY TO REGISTER TO VOTE.

( ) I DO WANT TO APPLY TO REGISTER TO VOTE. PLEASE SEND ME A VOTER REGISTRATION FORM.

APPLYING TO REGISTER OR DECLINING TO REGISTER TO VOTE WILL NOT AFFECT THE ASSISTANCE OR SERVICES THAT YOU WILL BE PROVIDED BY THIS AGENCY. A DECISION NOT TO APPLY TO REGISTER TO VOTE WILL REMAIN CONFIDENTIAL. A DECISION TO APPLY TO REGISTER TO VOTE AND THE OFFICE WHERE YOUR APPLICATION WAS SUBMITTED WILL ALSO REMAIN CONFIDENTIAL AND MAY ONLY BE USED FOR VOTER REGISTRATION PURPOSES. IF YOU BELIEVE THAT SOMEONE HAS INTERFERED WITH YOUR RIGHT TO REGISTER OR TO DECLINE TO REGISTER TO VOTE, YOUR RIGHT TO PRIVACY IN DECIDING WHETHER TO REGISTER TO VOTE, OR YOUR RIGHT IN APPLYING TO REGISTER TO VOTE, YOU MAY FILE A COMPLAINT WITH: SECRETARY OF VIRGINIA STATE BOARD OF ELECTIONS, NINTH STREET OFFICE BUILDING, 200 NORTH NINTH STREET, RICHMOND, VA 23219-3497. THE PHONE NUMBER IS (804) 786-6551.

**********AGENCY USE ONLY **********

	ELEMENTS OF EVALUATION	VERIFICATION/PERTINENT INFORMATION	MEETS ELIGIBILITY REQUIREMENTS
A. 1.	VA RESIDENCY, IF QUESTIONABLE	_____	YES NO
2.	RECEIVES SSI CHECK If no, have the individual complete the Application for Benefits.	SDX_____SVES_____OTHER_____	YES NO
3.	SSI CONDITIONAL/PRESUMPTIVE	_____	YES NO
4.	ASSET TRANSFER	_____	YES NO
5.	RESOURCES (IF HAS A TRUST OR OWNS UNDIVIDED HEIR PROPERTY, CONTIGUOUS PROPERTY, FORMER HOME, OR OTHER REAL PROPERTY)	_____ _____	
	VALUE OF COUNTABLE RESOURCES	$_____	YES NO

B. RECOMMENDATION

1. CURRENT ELIGIBILITY: ELIGIBLE: _____ EFFECTIVE DATE: _____ INELIGIBLE_____
2. RETROACTIVE ELIGIBILITY: ELIGIBLE: _____ EFFECTIVE DATE: _____ INELIGIBLE_____

WORKER'S SIGNATURE; _____ DATE: _____

SUPERVISOR'S SIGNATURE: _____ DATE: _____

C. ENROLLMENT

SPEC REVIEW: _____ CTY: _____ CI: _____ BEGIN: _____ END: _____ TYPE: _____

PD: 11 _____ 31 _____ 51 _____ APP DATE: _____ MEDICAL RESOURCE: _____ TYPE COV: _____

INS CO: _____ POLICY NUMBER: _____ BEGIN DATE: _____ END DATE: _____

COMMONWEALTH OF VIRGINIA DEPARTMENT OF SOCIAL SERVICES **MEDICAID APPLICATION FOR MEDICALLY INDIGENT PREGNANT WOMEN**	**AGENCY USE ONLY** DATE RECEIVED	
	CASE NAME/NUMBER	
	LOCALITY	WORKER

Please complete all sections of this form and return it to the local department of social services in the city/county in which the pregnant woman resides. If you need assistance in completing the form, please contact an eligibility worker at the LDSS.

I. IDENTIFYING INFORMATION: List the name, address, and phone number of the pregnant woman. If you are her authorized representative, please complete the application as if you were the pregnant woman.

Last Name First
Address City State Zip City/County of Residence
Mailing Address (If Different)

II. HOUSEHOLD INFORMATION: List the pregnant woman as person 1. Then list the following individuals in the home as persons 2, 3, and 4: her parents if she is under 21, her children, and her spouse. If there are more than four people, please complete a second form. A social security number is required only for the pregnant woman.

	PERSON 1	PERSON 2	PERSON 3	PERSON 4
Full Name				
Relationship to Person 1	Self			
Sex & Race				
Marital Status – (Married, Never Married, Divorced, Widowed)				
Date of Birth				
Place of Birth		NA	NA	NA
Social Security #				
US Citizen? (Y/N)? If no, alien #.		NA	NA	NA
Date pregnancy began		NA	NA	NA
Do you have health insurance? (Y/N) If yes, list company name and policy number.		NA	NA	NA

III. List all income received by the household. Include earnings, social security benefits, support, unemployment benefits, pensions, sick pay, student loans, farm income, and property or room rental.

	PERSON 1	PERSON 2	PERSON 3	PERSON 4
Name of employer or source of income				
How often is the income received?				
Amount before deductions?				

Are you paying adult or child care while you work? (Y/N) For whom? _____

How much? How often?

IV. Have you been to a doctor's office or clinic, received a prescription drug, or received a medical service in the three months before this month? [ ] Yes [ ] No If yes, list months. _____

V. Have there been any changes in your living arrangements, marital status, or income in the last three months?

[ ] Yes [ ] No If yes, describe the changes:_____

RIGHTS AND RESPONSIBILITIES

I understand that to receive benefits from the Medicaid program, I must agree to assign my right to medical support and other third-party payments to the Department of Medical Assistance Services. I understand that all money I receive for diagnosis or treatment of any injury, disease, disability, or medical care support must be sent to the Third-Party Liability Section, Department of Medical Assistance Services, Suite 1300, 600 East Broad Street, Richmond, VA 23219. I understand that my refusal to assign my rights will result in my ineligibility for Medicaid.

I understand that I have the right to file a complaint if I feel I have been discriminated against because of race, color, national origin, sex, age, handicap, or religious belief. I understand that I have the right to appeal and have a fair hearing if I am: (1) not notified in writing of the decision regarding my application within 10 days; (2) denied benefits from the Medicaid Program; or (3) dissatisfied with any other decision that affects my receipt of Medicaid.

I understand that refusal to cooperate with a review of my Medicaid eligibility by Quality Control will make me ineligible for Medicaid until I cooperate with the review.

I authorize the Department of Social Services and the Department of Medical Assistance Services to obtain any verifications necessary to establish my eligibility for assistance. I authorize the release to the Department of Medical Assistance Services of any information in any medical records pertaining to any services received by me.

I received the booklet: Medicaid Handbook [ ] YES [ ] NO

I filled in this form myself. [ ] YES [ ] NO If no, it was read back to me when completed. [ ] YES [ ] NO

I agree to report any changes in information on this form within 10 days of the change to my local department of social services.

I declare that all information I have given on this application is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report a change promptly or on purpose, I may be breaking the law and could be prosecuted for perjury, larceny, and/or welfare fraud. I understand that my signature on this application certifies, under penalty of perjury, that I am (unless applying for emergency services only) a U.S. Citizen or alien in lawful immigration status.

Signature or Mark: _____ Date: _____

Witness/Authorized Representative: _____ Date: _____

I completed this application/redetermination for _____. I understand that if I aided or abetted her to obtain assistance for which she is not eligible that I may be breaking the law and could be prosecuted.

Signature: _____

Address: _____

Relationship: _____Date: _____Telephone #:_____

VOTER REGISTRATION

Check one of the following:

( ) I am not registered to vote where I currently live now, and I would like to register to vote here today. I certify that a voter registration form was given to me to complete. (If you would like help in filling out the voter registration, we will help you. The decision to have us help you is yours. You also have the right to complete your form in private.)
( ) I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote.)
( ) I do not want to apply to register to vote.
( ) I do want to apply to register to vote, please send me a voter registration form.

Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right in applying to register to vote, you may file a complaint with: Secretary of Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497. The phone number is (804) 786-6551.

Agency Use Only: □ Face to face interview not required. A voter registration form was mailed.

Covering Children With Affordable Health Insurance

Children's Health Insurance

This is an application for FAMIS and FAMIS Plus, Virginia's health insurance programs for children under age 19. Instructions are attached.

Application is: ___a new application
___to continue insurance

Family ID # _____

Office Use Only: Case _____
Worker_____

Step 1 Information on the person completing the application:

Tell us who you are, where you live and where you get your mail.

First Name	MI	Last Name	Phone Numbers	Preferred Language? (See instructions)
			H ( ) W ( )	

Address	Apt No.	City	State	ZIP	City/County of Residence
(Street)					
(Mailing)					

Step 2 Information on Children:

Tell us about **all** the children under age 21 living in your home. If there are more than four children in the home, please complete steps 2 and 3 on another application (or on an Additional Child Form) and attach it to this application.

	Child 1	Child 2	Child 3	Child 4
Child's Full Name (Name: First, MI, Last)				
Relationship to You				
Date of Birth & Sex	___/___/___ ☐M ☐F	___/___/___ ☐M ☐F	___/___/___ ☐M ☐F	___/___/___ ☐M ☐F
Child's Parent or Stepparent Living In the Home (Name: First, MI, Last)	☐Mother ☐Father ☐Stepparent (SS#) Not Required	☐Mother ☐Father ☐Stepparent (SS#) Not Required	☐Mother ☐Father ☐Stepparent (SS#) Not Required	☐Mother ☐Father ☐Stepparent (SS#) Not Required
Child's Parent or Stepparent Living In the Home (Name: First, MI, Last)	☐Mother ☐Father ☐Stepparent (SS#) Not Required	☐Mother ☐Father ☐Stepparent (SS#) Not Required	☐Mother ☐Father ☐Stepparent (SS#) Not Required	☐Mother ☐Father ☐Stepparent (SS#) Not Required

Step 3 Information on Children Applying for Insurance:

	Child 1 *continued*	Child 2 *continued*	Child 3 *continued*	Child 4 *continued*
Child's Full Name (Name: First, MI, Last)				
Applying for Health Insurance for Child?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

If you are applying for insurance for this child, answer the questions below. If you are <u>not</u> applying for this child, you may leave them blank.

Is Child a US Citizen?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
	If **No**, Please Fill in the Following Information: Alien/INS # _____ Country of Birth _____ Date Entered _____	If **No**, Please Fill in the Following Information: Alien/INS # _____ Country of Birth _____ Date Entered _____	If **No**, Please Fill in the Following Information: Alien/INS # _____ Country of Birth _____ Date Entered _____	If **No**, Please Fill in the Following Information: Alien/INS # _____ Country of Birth _____ Date Entered _____
Child Social Security # or Date of Application for SS#	_____ (SS#)	_____ (SS#)	_____ (SS#)	_____ (SS#)
Child Attends School?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Child's Race (See codes listed below)	Race Code # _____	Race Code # _____	Race Code # _____	Race Code # _____
	RACE CODES: **1** White; **2** Black/African American; **3** American Indian/Alaskan Native; **4** Asian; **5** Spanish American/Hispanic; **6** Native Hawaiian or Other Pacific Islander; **9** Other or Unknown.			
Child's Ethnicity	Hispanic/Latino ☐ YES ☐ NO	Hispanic/Latino ☐ YES ☐ NO	Hispanic/Latino ☐ YES ☐ NO	Hispanic/Latino ☐ YES ☐ NO
Does Child Have Health Insurance Now? (See instructions for further explanation)	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
	If **YES**, Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____	If **YES**, Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____	If **YES**, Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____	If **YES**, Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____
Has Child Had Health Insurance in the Past 4 Months? (See instructions for further explanation)	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
	If **YES**, Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____	If **YES**, Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____	If **YES**, Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____	If **YES**, Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____
Why Did Insurance End in the Past 4 Months? (See reasons below)	Reason # _____ Other _____	Reason # _____ Other _____	Reason # _____ Other _____	Reason # _____ Other _____

REASONS CHILD'S HEALTH INSURANCE ENDED: (See Instructions) **1** Parent or stepparent changed jobs or stopped employment and no other employer contributes to the cost of family coverage. **2** Parent or stepparent's employer stopped contributing to the cost of family coverage and no other employer contributes to the cost of family coverage. **3** Insurance company discontinued coverage because child is uninsurable. **4** Cost of insurance exceeded 10% of monthly income (before taxes). **5** Insurance stopped/dropped by someone other than parent or stepparent living with child. **6** Stopped/dropped a COBRA policy. **7** Other

Step 4 Income Information:

Complete the section below for each parent, stepparent and child living in the home receiving income.

List each source of income separately. Include income from jobs, self-employment, child support, Social Security benefits, unemployment compensation, and any other income received. List all income amounts before taxes and other deductions (gross income). Do not include income received by guardians, grandparents or other relatives. If there is no family income, write "NONE" in the chart below. (See instructions for explanation of all types of income that must be listed and the proof of income that must be provided.)

Person Receiving Income	Employer's Name or Source of Income?	Is Employer a State or Local Government?	How Much Income is Received?	How Often is Income Received?
First Name MI Last Name		☐ YES ☐ NO	$	☐ Weekly ☐ Every Two Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly
First Name MI Last Name		☐ YES ☐ NO	$	☐ Weekly ☐ Every Two Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly
First Name MI Last Name		☐ YES ☐ NO	$	☐ Weekly ☐ Every Two Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly
First Name MI Last Name		☐ YES ☐ NO	$	☐ Weekly ☐ Every Two Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly
First Name MI Last Name		☐ YES ☐ NO	$	☐ Weekly ☐ Every Two Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

We have your permission to get information from the above employers, if necessary, about dates of employment and earnings. ☐ YES ☐ NO

Step 5 Childcare Expenses:

Do you pay someone to provide childcare while you work? ☐ YES ☐ NO If yes, provide information for each child in childcare.

(Child's name: First, MI, Last)	(Child's name: First, MI, Last)	(Child's name: First, MI, Last)	(Child's name: First, MI, Last)
How much do you pay? $ ____ How often? ____	How much do you pay? $ ____ How often? ____	How much do you pay? $ ____ How often? ____	How much do you pay? $ ____ How often? ____

You're almost done. Turn the page over, complete the application and remember to sign it.

Step 6 Help with Medical Bills:

If the child is eligible, FAMIS Plus may be able to help you with medical/dental services the child received in the last 3 months. Did any child you are applying for receive medical/dental services in the last 3 months? ☐ YES ☐ NO

If yes, list names of children and months in which they received medical/dental services:

_____

_____

_____

Provide proof of income for the months that child received medical/dental care. **DO NOT SEND MEDICAL/DENTAL BILLS TO FAMIS.**

Step 7 Release:

If you would like to have someone else contact us for you, please complete the following:

I authorize (name) _____

and/or (organization) _____

(address) _____

(city)_____ (state) _____ (zip) _____ (phone) _____

to request and receive eligibility/enrollment information relating to my child(ren). I also permit FAMIS, the local Department of Social Services, and/or the Department of Medical Assistance Services to release information about this application to this person/organization.

By signing below I certify that I have read my **Rights and Responsibilities** (located on the instructions page) and agree to all the conditions and terms. I also agree that all information I have given on this application is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report required changes promptly or on purpose, my children's health insurance may be denied or ended and I could be prosecuted for perjury, larceny and/or fraud.

_____
SIGNATURE (REQUIRED)

_____
DATE

FAMIS
Covering Children With Affordable Health Insurance

Children's Health Insurance

Application Instructions & Rights and Responsibilities

APPLICATION INSTRUCTIONS FOR FAMIS & FAMIS Plus

(FAMIS Plus is the new name for children's Medicaid)

How do I apply?

To get started, simply call our toll-free number **1-866-87-FAMIS (1-866-873-2647)** or fill out this application and mail it to **FAMIS P.O. Box 1820, Richmond, Virginia 23218-1820**, or fax it to **toll-free fax number 1-888-221-9402**. This application can also be mailed, dropped off or faxed to the **local Department of Social Services** in the City or County in which you live. Check the blue pages in your telephone book for the address and telephone number of your local Department of Social Services. It is not required that you visit FAMIS or your local Department of Social Services to apply.

Who can apply for a child?

Parents can apply for their children. An adult relative with whom the child lives may also sign an application on behalf of the child. An adult who has legal custody or guardianship may apply for a child but will need to attach a copy of court papers. A person authorized in writing, by a parent or legal guardian, to act on behalf of the parent may apply but must attach a signed authorization from the parent. Adults, married to a minor, may apply for their spouse, and children over 18 or emancipated by a court, may apply for themselves.

Step 1 **Information on person completing application:** Complete this section listing your name, address and phone number. If we may call you at work, include that phone number. Please tell us what language you prefer. Write the name of the language you prefer in the space provided, such as:

English, Spanish, Cambodian, Vietnamese, Farsi, Haitian-Creole, Laotian, Chinese, Korean, Somali, Kurdish, Arabic, French, German, Japanese, or any other language.

Step 2 **Information on children:** Provide information on all children under 21 who live in the home with you even if they are not applying for FAMIS or FAMIS Plus. Although you can only apply for children under age 19 on this form, we need information on all children under 21 to correctly determine the size of the family. If there are more than 4 children under age 21 in the home, complete sections 2 and 3 on another application and attach it to this one.

List the **name** of each child under age 21 who lives in the home with you, tell us how they are **related to you**, their **date of birth**, and check if they are **male or female**.

For each child under age 21 in the home please write the **name** of the child's **parents and/or stepparents** living in the home with the child. Check if they are the Mother, Father or Stepparent of the child. The Social Security Number (SS#) of each parent is not required information but it helps us check income and process the application. If you prefer, you may leave it blank.

Step 3 **Information on children applying:** Write the **name** of each child at the top of the same column again. Check whether you are **applying for health insurance** for each child. If you are not applying for health insurance for a child, you do not need to answer the rest of the questions in this section for that child. If you are applying for the child, answer all of the questions in the column.

If the child is a **US citizen** check yes. If the child is a **legal immigrant**, provide the child's INS #, country of birth and the date the child entered the U.S. Children who are legal residents may qualify for these health insurance programs. You must provide a copy of the front and back of the child's Resident Alien Card or other proof of immigration status with this application. This information is for our records only and will not affect the immigration status of your children and will not be shared with the INS. We do not need information on the immigration status of any adults in your family. The INS cannot use this application to deny you admission to the U.S., to harm your permanent resident status, or to deport you.

Unless you are applying solely for emergency medical services for a non-citizen child, a **Social Security Number** is required for all children applying for health insurance. If the child does not have a Social Security Number, you must provide proof that you have applied for one for the child.

Tell us if the child is currently **attending school**.

Enter the correct code number for the **Race** of each child. Codes are listed below the question on the application. Then check yes or no if the child is of Hispanic/Latino ethnic origin.

Having other health insurance does not affect a child's eligibility for FAMIS Plus but may affect eligibility for FAMIS. Tell us if your children have health **insurance now**, and what type of policy they have. (For example, comprehensive coverage, major medical, school-accident plan, dental coverage, etc.) Provide the name of the insurance company and the policy number.

Children are not eligible for FAMIS until they have been uninsured for 4 months unless there was a "good cause" **reason why the health insurance ended**. Tell us if each child had health insurance during the past **4 months**. If they did, tell us about the policy and the date it ended. Read the good cause reasons listed on the application and if any of them are true for this case, write the correct reason number in the space. If none of these reasons are correct, put #7 for "Other" and write a brief explanation of why the insurance ended. If the child's insurance was stopped because of the cost, (reason #4) you must provide proof of the monthly cost of the discontinued insurance. If the child's coverage was discontinued by an insurance company for a reason other than non-payment of premiums (reason #3), provide proof of this from the insurance company. If you want a further explanation of the good cause reasons or more information on what to include with the application, call **1-866-87-FAMIS** or your **local Department of Social Services. This rule does not apply to FAMIS Plus.**

Step 4 **Income information:** For each parent, stepparent and child under age 21 who lives in the home and receives income, list their **name** and the **source of the income**. If the income is from a job, list the name of the employer. If the income is from another source, (such as child support, unemployment compensation, Social Security, etc.) write the type or source of the income. Check if the person works for the **State of Virginia or for a local government agency**.

For each type of income listed, write the **amount of income** received and how often if it is received (**each week, every two weeks, twice a month, once a month or yearly**). Be sure to write the amount of income before any taxes or other deductions are taken out (gross income).

You also need to provide **proof of each type of income** a family member receives. You will need to provide proof of all income received in the month before you apply. (For example, if you were

applying in June, you would need to attach proof of all income received in the month of May. If you were applying in May you would need to provide proof of all income for April.)

To prove income from a job, please attach a copy of all paycheck stubs for last month showing gross pay. If you do not have paycheck stubs, you can send a signed letter from an employer stating how much the employee was paid for each pay period last month or you may call 1-866-87-FAMIS to request a special form for reporting employment income. If you are self-employed, provide your most current tax return and all schedules or business records for last month.

You must also provide proof of other types of income received. Examples of proof of other income include: Child support — a print out from the Division of Child Support Enforcement Web site for last month, or copies of all child support checks received last month, or a signed statement from the absent parent stating how much they pay each month; Social Security (SSA or SSI) — the current year award letter from the Social Security Administration; unemployment compensation — a copy of all checks received last month.

If income is different from month to month, you may provide proof of the last 3 months of income to show an average income. If you have questions about what income to report or what proof is needed, please call **1-866-87-FAMIS** or your **local Department of Social Services.**

Permission to contact employers: In some situations we may need to contact employers to get information about earnings. If you agree to let us do this in order to process this application, check yes.

Step 5 **Childcare Expenses:** Certain childcare expenses may help a child qualify for FAMIS Plus. Tell us if you **pay for childcare while** you work. If the answer is yes, write the **name** of each child in paid childcare and how much you pay for their childcare and how often you pay it. (For example, $50 a week or $200 a month.) You can even report this expense if you are paying a relative to care for the children. Also, report payments you make for adult daycare for an adult in your home that needs special care while you work.

Step 6 **Medical Bills:** If a child qualifies for FAMIS Plus, you may be able to get help with the child's **medical and dental bills for the past 3 months.** Tell us if a child applying for insurance has any medical bills during the last 3 months. If the answer is yes, write the **name** of the child or children who have medical bills and the **month** in which the child or children received the medical or dental service. You will also have to show proof of family income for that month so we can determine if the child or children would have qualified for FAMIS Plus at the time the medical care was received. If a child qualifies for FAMIS instead of FAMIS Plus, medical bills will only be covered from the first day of the month in which your signed application was received by FAMIS or at the local Department of Social Services. **DO NOT SEND MEDICAL OR DENTAL BILLS TO FAMIS OR FAMIS Plus.** If the child qualifies for this retroactive coverage, we can pay for bills submitted by doctors, hospitals, dentists, pharmacies, or other medical providers for medical/dental services provided to the child during that time. We cannot pay for bills sent from individuals.

Step 7 **RELEASE:** If someone has helped you with this application or you would like someone else to be able to receive information about this application on your behalf, **clearly print the person's name** or the name of an **organization** in this section. We will not release any information about this application to anyone except you, unless you tell us here who you want to be able to receive this information.

Before you sign this application, make sure all the information is correct and read the section on your **Rights and Responsibilities** carefully. When you sign the application you are agreeing to all the statements under the Rights and Responsibilities. **Sign and date the application.** We cannot process an unsigned application.

Final checklist: ☐ Did you answer all the questions?
☐ Did you attach proof of all of last month's income?
☐ Did you attach any other necessary documents?
☐ Did you sign the application?

Mail or fax to FAMIS or your local Department of Social Services today.

YOUR RIGHTS AND RESPONSIBILITIES
(Read this section before signing the application)

I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs, or disability consistent with state and federal law and I can file a complaint if I feel I have been discriminated against.
- Request, in writing, a hearing or review of any negative action that affects my child(ren)'s eligibility for or receipt of FAMIS or FAMIS Plus (formerly Medicaid) insurance, including timely decisions made on this application. I understand that there will be no opportunity for review of a negative action if the sole basis for the action is lack of funding for FAMIS.
- Receive services from the Division of Child Support Enforcement and receive the booklet "Child Support and You". I further understand that failure to apply for such services will not affect my child(ren)'s eligibility for FAMIS or FAMIS Plus.

I further understand and agree that:

- This application could lead to my child(ren)'s enrollment in either FAMIS **OR** FAMIS Plus and that my child will be enrolled in the appropriate program based on eligibility rules.
- My children are not eligible for FAMIS coverage if they are eligible for FAMIS Plus, if they are eligible for health coverage under the Commonwealth of Virginia's State Employee Health Insurance Plan, or if they are patients in an institution for mental diseases. Children who are inmates in a public correctional institution are ineligible for both FAMIS and FAMIS Plus.
- The State and its contractors may contact other state and federal agencies to verify any information that affects my child(ren)'s eligibility for insurance.
- The State and its contractors may exchange information on this application and medical, health, or other information relating to my child(ren)'s coverage with other agencies and contractors, including companies offering health insurance to my child(ren), to assist with application, enrollment, administration, quality control, and quality assurance. We will not share your information with the IRS or the INS.
- The Commonwealth of Virginia or its designee has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by my child(ren).
- Each provider of medical services to my child(ren) may release any medical or other information necessary for the provider to be paid.

If my child is enrolled in FAMIS, I understand:

- I will be responsible for paying a co-payment for some FAMIS services received by my child(ren) and the FAMIS case will be maintained by the FAMIS Central Processing Unit (CPU).
- I have the responsibility to report within 10 days of the change, certain increases in income or changes in family size as explained in the FAMIS handbook and if the child enrolled in FAMIS moves out of the state of Virginia. I must report such changes to the FAMIS CPU at 1-866-873-2647.

If my child is enrolled in FAMIS Plus, I understand:

- That FAMIS Plus was formerly known as Medicaid. The FAMIS Plus case will be maintained by the local Department of Social Services where the child lives.
- I have the responsibility to report any changes in information provided on this form within 10 days of the change. I must report this information to the local Department of Social Services that maintains the child's FAMIS Plus case.

FAMIS AND FAMIS PLUS MUST BE RENEWED AT LEAST **EVERY 12 MONTHS.**

IT IS VERY IMPORTANT THAT YOU REPORT ANY CHANGE IN YOUR ADDRESS TO THE AGENCY THAT IS MANAGING THE CHILD'S CASE. IF WE DO NOT HAVE A CORRECT ADDRESS, WE WILL NOT BE ABLE TO NOTIFY YOU WHEN IT IS TIME TO RENEW COVERAGE AND THE CHILD WILL BE CANCELLED FROM THE PROGRAM.

HELP US KEEP YOUR CHILDREN COVERED — TELL US IF YOU MOVE!

Upon implementation of FAMIS MOMS, the Health Insurance for Children and Pregnant Women application will be added to this manual and made available on-line at the following web sites:

- **http://www.localagency.dss.state.va.us/divisions/dgs/warehouse.cgi**
- **http://www.dss.virginia.gov/form/index.html**

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application

AGENCY USE ONLY

DATE RECEIVED:

CASE NAME/NUMBER:

LOCALITY: | WORKER

Please complete all sections. If you need assistance, please contact an eligibility worker at your local Department of Social Services.

1. IDENTIFYING INFORMATION

LAST NAME: | FIRST NAME: | MI: | SOCIAL SECURITY NUMBER:

ADDRESS: | CITY: | STATE: | ZIP: | STATE OF RESIDENCE:

MAILING ADDRESS (If different): | CITY: | STATE: | ZIP: | HOME PHONE #: | DAYTIME PHONE #:

2. ADDITIONAL INFORMATION

RACE: ☐ WHITE ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ BLACK ☐ ASIAN/PACIFIC ISLANDER ☐ HISPANIC ☐ OTHER

MARITAL STATUS: ☐ NEVER MARRIED ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

U. S. CITIZEN? YES ☐ NO ☐ IF NO, ALIEN NUMBER:

DO YOU RECEIVE SSI? YES ☐ NO ☐ ARE YOU PREGNANT? YES ☐ NO ☐ DO YOU HAVE A CHILD(REN) UNDER AGE 19 LIVING WITH YOU? YES ☐ NO ☐

DO YOU HAVE HEALTH INSURANCE? YES ☐ NO ☐ IF YES, COMPANY NAME: _____

POLICY #: _____ EFFECTIVE DATE: _____ TYPE OF COVERAGE: _____

DID YOU RECEIVE MEDICAL CARE IN ANY OF THE THREE MONTHS BEFORE THIS APPLICATION? YES ☐ NO ☐ IF YES, LIST MONTHS: _____

3. BCCPTA CERTIFICATION

I CERTIFY THAT THE ABOVE NAMED INDIVIDUAL IS A VIRGINIA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (BCCEDP) PARTICIPANT (TITLE XV) AND IS ELIGIBLE FOR MEDICAID UNDER THE BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000.

SCREENING DATE: _____ DIAGNOSIS DATE: _____ FACILITY/SERVICE SITE: _____ PHONE #: _____

SIGNATURE OF BCCEDP CASE MANAGER : _____ DATE: _____

YOUR RIGHTS AND RESPONSIBILITIES

By signing below, I agree to the following:
I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs or disability consistent with state and federal law and to file a complaint if I feel I have been discriminated against.
- Have my eligibility for Medicaid benefits determined within 10 working days of receipt of my application at my local department of social services *or be notified of the reason for any delay*.
- Appeal and have a fair hearing if I am: (1) not notified in writing of the decision regarding my application; (2) denied benefits from the Medicaid program; or (3) dissatisfied with any other decision that affects my receipt of Medicaid benefits.

I have the responsibility to:

- Not purposely withhold information, or give false information and understand if I do so my Medicaid coverage may be denied or ended.
- Report any changes in information provided on this form within 10 days to my local department of social services.
- Cooperate with a review of my Medicaid eligibility by Quality Control and understand that refusing to cooperate will make me ineligible for Medicaid until I cooperate with a review.

I further understand and agree that:

- This application is used only to apply for Medicaid under the Breast and Cervical Cancer Prevention and Treatment Act coverage group and that in order to apply under other coverage groups I must complete another application.
- The Department of Medical Assistance Services and the Department of Social Services are authorized to obtain any verification necessary to establish my eligibility for Medicaid.
- The Department of Medical Assistance Services has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by me.
- Each provider of medical services may release any medical records pertaining to any services received by me.
- I am assigning my rights to medical support and other third party payments to the Department of Medical Assistance Services in order to receive benefits from the Medicaid program.

I declare that all information I have given on this application is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information or fail to report a change promptly or on purpose I may be breaking the law and could be prosecuted for perjury, larceny and/or fraud. I understand that my signature on this application signifies, under penalty of perjury, that I am a U.S. citizen or alien in lawful immigration status.

_____ _____
Signature or Mark **Date**

_____ _____
Witness/Authorized Representative **Date**

VOTER REGISTRATION

Check one of the following:

( ) I am not registered to vote where I currently live now, and I would like to register to vote here today. I certify that a voter registration form was given to me to complete. (If you would like help in filling out the voter registration, we will help you. The decision to have us help you is yours. You also have the right to complete your form in private.)
( ) I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote.)
( ) I do not want to apply to register to vote.
( ) I do want to apply to register to vote, please send me a voter registration form.

Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right in applying to register to vote, you may file a complaint with: Secretary of Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497. The phone number is (804) 786-6551.

BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT (BCCPTA) MEDICAID APPLICATION

FORM NUMBER - 032-03-384

PURPOSE OF FORM - This form is the Medicaid application form for women who have been screened and diagnosed with breast or cervical cancer by a medical provider operating under the Center for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP) and who have been certified as needing treatment.

USE OF THE FORM - This form is used to collect the information needed to determine Medicaid eligibility in the BCCPTA covered group and enroll eligible *women* in the VaMMIS. Initial eligibility in the BCCPTA covered group cannot be determined unless the screening certification in Section 3 is signed by a provider or certifying individual under the authority of the CDC BCCEDP.

NUMBER OF COPIES - Original.

DISPOSITION OF FORM - The original is filed in the case record.

INSTRUCTIONS FOR PREPARATION OF THE FORM

Section 1: Section 1 is used to collect identifying information for the applicant/recipient.

Section 2: Section 2 is used to obtain the nonfinancial information used to determine eligibility in the BCCPTA covered group.

Section 3: Section 3 is the certification that the woman is a BCCEDP participant and is eligible for Medicaid under the BCCPTA. This certification must be signed by a provider or certifying individual under the authority of the CDC BCCEDP.

The rights and responsibilities and voter registration are on the reverse side of the form.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

TITLE IV-E FOSTER CARE &
MEDICAID* APPLICATION/REDETERMINATION
*(Separate Medicaid application required for noncustodial agreement cases)

CASE NUMBER_____CLIENT ID_____
COUNTY/CITY_____
WORKER_____
☐ APPLICATION ☐ REDETERMINATION ☐ ADOPTION ASSISTANCE SCREENING

I. IDENTIFYING INFORMATION

CHILD'S NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SEX	RACE	SSN ☐ OR DATE APPLIED FOR SSN ☐

MOTHER'S NAME ADDRESS SSN	FATHER'S NAME ADDRESS SSN

IF THE CHILD WAS RECEIVING OTHER ASSISTANCE WHEN BROUGHT INTO FOSTER CARE, GIVE THE CASE NAME AND/OR CASE NUMBER

II. COMMITMENT INFORMATION

COURT ORDER		VOLUNTARY PLACEMENT AGREEMENT (VPA)	
☐ INITIAL COURT ORDER DATED OR ☐ ANNUAL JUDICIAL REVIEW DATED _____ COPY ATTACHED? ☐ YES ☐ NO	REQUIRED JUDICIAL LANGUAGE REASONABLE EFFORTS? ☐ YES ☐ NO CONTRARY TO THE WELFARE ? ☐ YES ☐ NO	CHECK VPA TYPE ☐ TEMPORARY ENTRUSTMENT ☐ PERMANENT ENTRUSTMENT ☐ NONCUSTODIAL AGREEMENT	VPA DATED _____ COPY ATTACHED? ☐ YES ☐ NO

III. PLACEMENT INFORMATION

TYPE PLACEMENT ☐ FOSTER HOME ☐ FOR PROFIT CPA FOSTER HOME ☐ NONPROFIT CPA FOSTER HOME
☐ PUBLIC INSTITUTION SERVING 25 OR LESS ☐ PRIVATE RESIDENTIAL FACILITY ☐ OTHER _____
PLACEMENT NAME & ADDRESS
_____
_____
IF THE CHILD IS A QUALIFIED ALIEN, IS PLACEMENT WITH AN UNQUALIFIED ALIEN FOSTER PARENT? ☐ YES ☐ NO

DATE OF PLACEMENT

APPROVED FROM/TO

VERIFICATION ATTACHED? ☐ YES ☐ NO

MONTHLY MAINTENANCE COSTS (Food, clothing, shelter, daily supervision, school supplies, personal incidentals, liability insurance on child, and reasonable travel for child's visitation with family or other caretakers)

FC CHILD CHILD OF FC CHILD

IV. NON-FINANCIAL INFORMATION ☐ APPLICATION ☐ REDETERMINATION (Omit #1 - 5)

1. ELIGIBILITY MONTH:_____
(month court action was initiated/petition filed or entrustment/noncustodial agreement was signed)

2. LAST PLACE OF RESIDENCE_____ (city & state)

3. SPECIFIED RELATIVE/REMOVAL HOME DATE REMOVED _____ IF NOT REMOVED, ENTER REASON
_____

NAME OF PARENT/RELATIVE WITH WHOM THE CHILD LAST LIVED _____. WAS THE CHILD REMOVED FROM THIS PARENT/RELATIVE?

☐ YES COMPLETE #5 BELOW FOR THE ELIGIBILITY MONTH (this is the removal home)
☐ NO COMPLETE #4 AND #5. (the removal home is the home where the child last resided within six months of the eligibility month)

4. LIST ALL LIVING ARRANGEMENTS FOR THE SIX MONTH PERIOD PRIOR TO THE ELIGIBILITY MONTH

FROM/TO	NAME & ADDRESS	RELATIONSHIP

5. LIST PARENT/RELATIVE, MINOR SIBLINGS, STEPPARENT, AND CHILD OF THE FOSTER CARE CHILD RESIDING IN THE REMOVAL HOME.
NAME & ADDRESS_____
MINOR SIBLINGS OF CHILD (Include age and deprivation reason for each child)_____
STEPPARENT_____ CHILD OF FC CHILD_____ NUMBER IN FAMILY UNIT_____

6. DEPRIVATION - WAS THE CHILD DEPRIVED OF PARENTAL SUPPORT AND CARE OF ONE OR BOTH PARENTS DUE TO:

A. CONTINUED ABSENCE FROM HOME OF A PARENT	☐ YES ☐ NO	WHICH PARENT(S):	_____
B. PATERNITY NOT ESTABLISHED	☐ YES ☐ NO	NAME, IF KNOWN:	_____
C. DEATH OF A PARENT	☐ YES ☐ NO	WHICH PARENT(S):	_____
D. INCAPACITATED PARENT (BOTH PARENTS IN THE HOME)	☐ YES ☐ NO	WHICH PARENT(S):	_____
E, UNEMPLOYED PARENT (BOTH PARENTS IN THE HOME)	☐ YES ☐ NO	WHICH PARENT(S):	_____
F. PARENTAL RIGHTS TERMINATED MOTHER	☐ YES ☐ NO	FATHER	☐ YES ☐ NO (n/a for applications)

7. CITIZENSHIP/ALIENAGE DECLARATION (REQUIRED BY LAW UNDER PENALTY OF PERJURY) CHILD IS: U.S. CITIZEN ☐ ALIEN ☐
ALIEN NUMBER _____ ENTRY DATE_____ (Attach INS document) ☐ UNDOCUMENTED ALIEN

8. ENROLLED IN SCHOOL? ☐ YES ☐ NO NAME OF SCHOOL_____ GRADE_____
IF CHILD IS 18, IS HE/SHE EXPECTED TO COMPLETE THE COURSE OF STUDY BY AGE 19? ☐ YES ☐ NO

9. CHILD SUPPORT REFERRAL (Application only) - COPY ATTACHED FOR EACH ABSENT PARENT? ☐ YES ☐ NO
IF GOOD CAUSE IS CLAIMED, EXPLAIN_____

V. TITLE IV-E SCREENING - RESOURCES (Indicate amount/value, as appropriate, and date/method verified.)

PROPERTY OWNED BY (Initial eligibility - AFDC assistance unit Ongoing case - FC child only)	FC CHILD		MOTHER	FATHER	SIBLINGS
	Eligibility Month	Situation Changed? If Yes, Explain	Eligibility Month	Eligibility Month	Eligibility Month
CASH					
CHECKING ACCOUNT (name of bank, account #, current balance)					
SAVINGS ACCOUNT (name of bank, account #, current balance)					
SPECIAL WELFARE FUND (current balance)					
IRA/CD (name of bank, account #, current amount available)					
STOCKS/BONDS (current amount available))					
TRUST FUND (current amount available)					
BURIAL FUND (current value)					
LIFE INSURANCE (name of company, policy #, cash value)					
VEHICLE (year, make, model, equity value)					
OTHER (specify type of resource and date/method of verification)					

VI. TITLE IV-E SCREENING - INCOME (Indicate amount and how often received, if applicable, and date/method verified.)

INCOME RECEIVED BY (Initial eligibility - AFDC assistance unit Ongoing case - FC child only)	FC CHILD		MOTHER	FATHER	SIBLINGS
	Eligibility Month	Situation Changed? If Yes, Explain	Eligibility Month	Eligibility Month	Eligibility Month
EARNED					
SSA					
SSI					
VETERANS BENEFITS					
SUPPORT					
RETIREMENT/PENSIONS					
MILITARY ALLOTMENT					
UNEMPLOYMENT COMPENSATION					
WORKER'S COMPENSATION					
OTHER (specify)					

VII. MEDICAL INFORMATION AND ASSIGNMENT OF RIGHTS

DOES THE CHILD HAVE MEDICAL INSURANCE? ☐ YES ☐ NO
IF YES, PROVIDE THE FOLLOWING INFORMATION:

1. NAME AND ADDRESS OF COMPANY

2. POLICY HOLDER | 3. POLICY # | 4. TYPE COVERAGE | 5. EFFECTIVE DATE

DOES THE CHILD HAVE UNPAID MEDICAL BILLS INCURRED DURING THE THREE MONTHS PRIOR TO APPLICATION? ☐ YES NO ☐ UNKNOWN
IF YES, ATTACH SHEET SHOWING INCOME AND RESOURCES DURING THE THREE MONTHS PRIOR TO APPLICATION.

IF YES, GIVE THE DATE EACH EXPENSE WAS INCURRED. _____

ADDRESS TO WHICH THE MEDICAID CARD SHOULD BE SENT

_____
(Name) (Address) (City, State, &Zipcode)

IN ORDER TO RECEIVE MEDICAID, EACH FOSTER CHILD MUST HAVE HIS/HER RIGHTS TO MEDICAL SUPPORT ASSIGNED TO THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS). THIS MEANS THAT DMAS MUST BE REIMBURSED FOR PAYMENT OF ANY MEDICAL SERVICES RECEIVED FROM ANOTHER INSURER.

☐ I AGREE TO ASSIGN THE RIGHTS OF THE ABOVE NAMED FOSTER CHILD FOR WHOM I HAVE THE LEGAL RIGHT TO DO SO.

☐ I REFUSE TO ASSIGN THE RIGHTS OF THE ABOVE NAMED FOSTER CHILD.

_____ _____
(Signature of Service Worker) (Date)

TITLE IV-E FOSTER CARE & MEDICAID APPLICATION/REDETERMINATION FORM

FORM NUMBER – 032-03-636

PURPOSE OF FORM – The form serves as a referral for Title IV-E foster care and adoption assistance screening and an application for Medicaid with one exception. When a child enters care through a noncustodial agreement, a separate Medicaid application must be completed and signed by the parent or guardian.

USE OF FORM – This form is to be completed by the service worker and sent to the eligibility worker for use in evaluating Title IV-E and Medicaid eligibility.

NUMBER OF COPIES – IV-E Foster Care and Medicaid - Complete one copy of the IV-E foster care/Medicaid application when an initial referral/application is made and for each subsequent redetermination of eligibility.

Adoption Assistance - Complete two forms: one to provide information necessary to determine initial IV-E foster care eligibility requirements and one to provide information needed to determine eligibility in the month the adoption petition was filed.

DISPOSITION OF FORM – The form is to be filed in the eligibility case record.

CHAPTER M01
MEDICAID APPLICATION
SUBCHAPTER 30

APPLICATION PROCESSING

TABLE OF CONTENTS

M01 MEDICAID APPLICATION

M0130.000 Application Processing

Appendix

M0130.100 Processing Time Standards

A. General Principle

Agencies are required by the State Plan to adhere to prescribed standards for the processing of Medicaid applications. The amount of time allowed to process an application is based on the covered group under which the application must be evaluated.

B. Processing Time Standards

1. 10 Day Requirement (Expedited Application)

a. Medically Indigent (MI) Pregnant Women

Applications for MI pregnant women must be processed within 10 working days of the agency's receipt of the signed application form.

If the pregnant woman also applies for other children or other persons in her family and the agency cannot determine the other persons' eligibility within 10 working days, the agency must determine just the Medicaid eligibility of the medically indigent pregnant woman within the working 10 days.

The agency must have all necessary verifications within the 10 working days in order to determine eligibility. If the agency does not receive the verifications within the 10 working days, the worker must send the applicant a Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs (NOA), form #032-03-008 (see M013, Appendix 1), on the 10th day. The NOA must state why action on the application was not taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 days by which to submit the documentation.

Once all necessary verifications for the pregnant woman are received, an eligibility decision must be made immediately and the applicant must be immediately notified of the decision. If the pregnant woman applied for other persons in the family, and the eligibility determination for those persons has not been completed, the NOA must state that the application is still pending.

If all necessary verifications are not received, the application continues to pend until the 45-day processing time limit is reached.

b. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Applications

BCCPTA Medicaid applications filed by women who do not meet the description of an individual in the LIFC, MI pregnant women, or the SSI recipients covered groups must be processed within 10 working days of the agency's receipt of the signed application.

BCCPTA Medicaid applications filed by women who meet the description of an individual in the LIFC, MI pregnant women, or the SSI recipients covered groups must be processed as soon as possible, but no later than 45 days of the agency's receipt of the signed application.

If the BCCPTA Medicaid application is the only application required and no additional information is required, the eligibility decision must be made immediately and the applicant must be notified of the decision within 10 working days of the agency's receipt of the application.

If a decision cannot be made within 10 working days of receipt of the BCCPTA application, the worker must send a NOA on the 10th day stating why action has not been taken, specifying what information is needed, and a deadline for submitting the information.

If all necessary verifications are not received, the application continues to pend until the 45-day processing time limit is reached.

2. 45/90 Day Requirement

Applications, including requests for retroactive coverage, must be processed within 45 days for all applicants other than MI pregnant women, women in the BCCPTA covered group, or individuals needing a disability determination. For individuals who must receive a disability determination, the time standard is 90 days.

The time standard begins with the date of receipt of a signed application and ends with the date of enrollment or the date the notification of denial of Medicaid is mailed to the applicant. The applicant must be informed of the agency's time standards.

The eligibility worker must allow at least 10 days to receive the necessary verifications. If all necessary verifications are not received, the application continues to pend until the 45-day processing time limit is reached.

3. Processing Priority

Application processing priority must be given to applicants who are in need of Medicaid coverage for nursing facility or community-based long-term care, hospice care, or who are in emergent need of other Medicaid-covered services. These applications must be processed as quickly as possible.

4. Time Standard Exceptions

The specified time standards apply unless the agency cannot reach a decision within the time standard because of one of the following reasons:

- the applicant's inability to furnish necessary information for a reason beyond his/her control,
- a delay in receipt of information from an examining physician,
- a delay in the disability determination process,
- a delay in receiving DMAS decision on property transfer undue hardship claim, or
- an administrative or other emergency beyond the agency's control.

If action is not taken within the time standard, the case record must show the cause for the delay and the applicant must be notified in writing of the status of his application, the reason for the delay, and his right of appeal.

When an application is delayed after 90 days because of a disability decision and the agency has determined that excess resources exist at the time the delay notice is sent, the NOA must inform the applicant that he/she has excess resources and the amount. The notice must also state that:

- a final action cannot be taken until the disability decision is made;
- if the applicant is determined to be disabled, he/she will not be eligible unless the excess resources are reduced; and
- he will be notified when the disability decision is made.

C. Application for Retroactive Coverage

When an applicant for Medicaid reports that he, or anyone for whom he requests assistance, received a medical service within the three months prior to application, retroactive Medicaid eligibility must be determined. The retroactive period is based on the month in which the application is filed with the agency. The retroactive period is the three months prior to the application month.

Retroactive coverage can be requested at any time subsequent to an application even if the application was denied or the applicant signed a statement saying he did not want retroactive coverage. The retroactive period is based on the application month regardless of whether the application was denied or approved.

If the application was denied, the application is reopened for determination of eligibility in the three months prior to the application month. The applicant must provide all verifications necessary to determine eligibility during that period.

If the applicant is found eligible for retroactive coverage and a Medicaid-covered medical service was received over one year prior to the date the retroactive eligibility is determined, the applicant must be given an "Eligibility Delay" letter to give to the medical provider so that Medicaid will pay the claim (see M1510, Appendix 1).

Once retroactive eligibility is established, Medicaid coverage begins the first day of the earliest retroactive month in which eligibility exists.

M0130.200 Required Information and Verifications

A. Identifying Information

An application must contain basic identifying information about the applicant. Basic identifying information is the applicant's name, address, Social Security number or application for the number, and date of birth.

B. Required Verifications

An individual must provide verifications of most Medicaid eligibility requirements. Before taking action on the application, the applicant must be notified in writing of the required information. The eligibility worker must allow at least 10 days for receipt of the necessary verifications, but additional time may be allowed depending on the type of information requested. The specific information requested and the deadline for receipt of the verifications must be documented in the case record.

If information necessary to make an eligibility determination is requested but not provided by the applicant and cannot be obtained from any other source, the application must be denied or the coverage cancelled due to the inability to determine eligibility.

C. Verification of Nonfinancial Eligibility Requirements

The applicant's statements on the application may be accepted for the following identifying information and nonfinancial eligibility requirements unless the eligibility worker has reason to question the applicant's statements:

- U.S. citizenship, if born in the U.S.,
- Virginia state residency,
- application for other benefits,
- institutional status,
- age for children under age 19,
- Social Security number (see section D below), and
- health insurance information (see sections E and F below).

The following information must be verified:

- age of applicants age 65 and older,
- disability and blindness,
- pregnancy, and

- dependent child information for applicants applying as parents or caretaker-relatives of a dependent child.

See subchapter M0310 for instructions on the verification of non-financial requirements.

D. Social Security Numbers

Applicants must provide the Social Security number of any person for whom they request Medicaid. An individual who is applying only for others and is not applying for himself is not required to provide a Social Security number for himself.

If a Social Security number has not been issued, the applicant must cooperate in applying for such a number with the local Social Security Administration Office. An Enumeration Referral Form, form #032-03-400, must be completed by the applicant. The applicant must provide the Social Security number to the local social services department as soon as it is received and the number must be recorded in the Medicaid computer applicant file. Applicants who refuse to furnish a Social Security number or to show proof of application for a number will be ineligible for Medicaid.

In the case of a newborn child not born to a Medicaid-eligible woman, the applicant can request hospital staff to apply for a Social Security number for the child through hospital enumeration procedures. Form #SSA-2853 will be given to the applicant as proof of application for a Social Security number.

Exceptions:

- Children under age one born to Medicaid-eligible mothers are deemed to have applied and been found eligible for Medicaid, whether or not eligibility requirements have actually been met, so long as the mother remains eligible and they continue to live together. A child eligible in this category does not need a Social Security number.

- Aliens who are eligible for emergency Medicaid services only are not required to provide or apply for Social Security numbers (see M0220)

E. Third Party Liability (TPL)

Applicants must be asked to provide information about any health insurance they may have. The eligibility worker must enter that information into the Medicaid Management Information System (MMIS) TPL file. Verification of health insurance information is not required.

In the event the client is eligible for benefits to be used exclusively for the payment of medical expenses (i.e. an insurance settlement), but there is no TPL code for that benefit, the worker must forward the information to:

Department of Medical Assistance Services
Third Party Liability Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

F. Health Insurance Payment Program (HIPP)

If a member of the assistance unit is employed more than 30 hours per week *and is eligible for coverage under an employer's group health plan*, the applicant must be assisted in completing the HIPP Application and the Medical History Questionnaire. Applicants are to be given the Insurance Verification Form to be given to the employer (See M0290).

G. Verification of Financial Eligibility Requirements

The eligibility worker must verify the following financial eligibility requirements:

- the value of all countable, non-excluded resources;
- all earned and unearned income; and
- asset transfer information, including the date of transfer, asset value, and compensation received, unless the money was used to buy food or personal items and no receipt was kept, and the amount claimed by the applicant is reasonable given the applicant's circumstance.

The State Verification Exchange System (SVES) must be accessed when verification of Social Security and/or Supplemental Security Income is not readily available to the applicant. The State Data Exchange (SDX) system should only be used as an alternate method when the applicant's SSN is not required or when the SVES record is unavailable. If the SDX system is used to verify benefits the case record must be documented to show why SVES was not used.

Chapters M05 through M11 include specific instructions for the verification of resources and income. Subchapter M1450 includes instructions for verifying the transfer of assets.

M0130.300 Eligibility Determination Process

A. Evaluation of Eligibility Requirements

The eligibility determination process consists of an evaluation of an individual's situation that compares each of the individual's circumstances to an established standard or definition. The applicant must be informed of all known factors that affect eligibility.

Eligibility decisions are made following a prescribed sequence:

- The applicant must meet all non-financial requirements, including a covered group.
- If applicable to the covered group, resource limits must be met.

- The income limits appropriate to the covered group must be met.

Subchapter M0210 contains the general principles of Medicaid Eligibility determination.

B. Hierarchy of Covered Group

An applicant must be evaluated for eligibility in all potential covered groups and enrolled in the group that is the most beneficial to the applicant. First, evaluate under covered groups offering full coverage and if the applicant is not eligible, evaluate under groups offering partial coverage. Further specific instructions regarding the determination of covered group are contained in chapter M03.

C. Applicant's Choice of Covered Group

An individual who meets more than one covered group may choose the covered group under which he wishes his eligibility determined. Appropriate policy used is based on that individual's choice. If the choice is not clear on the application/redetermination form, the individual must state his covered group choice in writing. If the applicant does not make a choice, enroll him in the covered group that is the most beneficial.

D. Application Disposition

1. General Principle

Each application must be disposed of by a finding of eligibility or ineligibility as supported by the facts in the case record, unless the application is withdrawn or terminated (see M0130.400).

2. Enrollment

Medicaid cases must be enrolled in the Medicaid Management Information System (MMIS). *Effective June 16, 2003, a new MMIS system, known as Virginia Medicaid Management Information System (VaMMIS) was implemented. The Medicaid Eligibility Manual contains enrollment instructions based on the former MMIS. Some terminology and procedures used in the VaMMIS differ from those used with the former MMIS. When following enrollment instructions in this manual, please note the following changes:*

- *The program designation (PD) is now known as aid category (AC). The AC is now the former PD prefaced by the digit "0." (e.g. AC 051).*
- *Coverage types are no longer used to enroll limited periods of coverage. Coverage is determined by begin and end dates.*
- *The former cancel reasons are now prefaced by the digit "0" (e.g. cancel reason 007).*

When enrolling an individual in *VaMMIS*, the appropriate *aid category AC* for the applicant's covered group must be used. Enrollment procedures and a list of *ACs* are found in the *Virginia MMIS* User Manual.

3. Notification to Applicant

The Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs (NOA), form #032-03-008 (see M0130, Appendix 1) must be used to notify the applicant when:

- the application has been approved, including the effective date(s) of his Medicaid coverage;
- the retroactive Medicaid coverage was approved, including the effective dates;
- the application has been denied, including the specific reason(s) for denial cited from policy;
- retroactive Medicaid coverage was denied, including the specific reason(s) for denial cited from policy;
- there is a reason for delay in processing his application;
- a request for re-evaluation of an application in spenddown status has been completed; and
- a child has been approved or denied (including the specific reason for denial cited from policy) for FAMIS (see M21).

A copy of the notice must also be mailed to the individual who has applied on behalf of the applicant.

E. Notification for Retroactive Entitlement

There are instances when an applicant is not eligible for ongoing eligibility but is eligible for retroactive benefits or a change in the applicant's situation during the application process results in the applicant being eligible for only a limited period of time. Only one NOA is sent to the applicant covering both actions. Statements of the exact dates of eligibility, the date of ineligibility, and the reason(s) for ineligibility must be included on this notice.

M0130.400 Applications Denied Under Special Circumstances

A. General Principle

When an application is withdrawn or the applicant cannot be located, the application is denied. The reason for the denial must be recorded in the case record, and a Notice of Action on Medicaid must be sent to the applicant's last known address.

B. Withdrawal

An applicant may withdraw his application at any time. The request must be written and documented in the record. When the applicant withdraws an application, the eligibility worker must send a Notice of Action on Medicaid.

An applicant may voluntarily withdraw only his application for retroactive coverage by signing a statement specifically indicating the wish to withdraw the retroactive coverage part of the application.

C. Inability to Locate

The agency must send a letter to the last known address informing the applicant of the agency's attempt to locate him and asking that he contact the office. For applicants who are documented as homeless, maintain all correspondence at the local agency. If the applicant does not respond within 45 days of the date of application, deny the application.

D. Duplicate Applications

Applications received requesting Medicaid and/or FAMIS for individuals who already have an application recorded or *who are currently active will be denied due to duplication of request. A Notice of Action on Medicaid will be sent to the applicant when a duplicate application is denied.*

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

NOTICE OF ACTION ON MEDICAID AND FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS) PROGRAMS

COUNTY/CITY	CASE NUMBER:
CASE NAME:	

ACTION ON YOUR MEDICAID OR FAMIS APPLICATION WAS TAKEN BY THE DEPARTMENT OF SOCIAL SERVICES ON _____. THE STATEMENT FOLLOWING THE CHECKED BLOCK EXPLAINS THE ACTION TAKEN.

☐ APPROVED FULL MEDICAID COVERAGE: BEGINS: _____ PERSONS ELIGIBLE: _____

☐ APPROVED LIMITED MEDICAID COVERAGE: QMB _____ SLMB _____ QI1 _____ QI2 _____ EMERGENCY ONLY _____

BEGINS: _____ PERSONS ELIGIBLE: _____

☐ MEDICAID COVERAGE WILL END _____ UNLESS YOU BECOME INELIGIBLE BEFORE THIS DATE.

☐ APPROVED FOR FAMIS: BEGINS: _____ PERSONS ELIGIBLE: _____

YOUR CHILD(REN)'S CASE HAS BEEN TRANSFERRED TO FAMIS. YOU WILL BE RECEIVING INFORMATION FROM FAMIS ABOUT YOUR CHILD'S COVERAGE. IF YOU HAVE QUESTIONS OR NEED FURTHER INFORMATION, PLEASE CALL FAMIS AT 1-866-873-2647.

☐ APPROVED RETROACTIVE MEDICAID COVERAGE FOR THE DATES OF: _____ PERSONS ELIGIBLE: _____

_____

☐ DENIED RETROACTIVE MEDICAID COVERAGE FOR THE MONTHS OF: _____

REASON: _____ MANUAL REFERENCE: _____

☐ DID NOT EVALUATE RETROACTIVE MEDICAID COVERAGE. NO SERVICES WERE REPORTED OR THE APPLICATION WAS WITHDRAWN.

☐ DENIED FULL MEDICAID COVERAGE BECAUSE INCOME EXCEEDS THE INCOME LEVEL.

IF MEDICAL OR DENTAL EXPENSES OF $ _____ ARE INCURRED BETWEEN _____ AND _____

OR MEDICAL OR DENTAL EXPENSES OF $ _____ ARE INCURRED BETWEEN _____ AND _____,

PLEASE BRING BILLS TO THE AGENCY AND ELIGIBILITY FOR FULL COVERAGE WILL BE RE-EVALUATED.

☐ DENIED MEDICAID COVERAGE

FOR: _____

REASON: _____

MANUAL REFERENCE: _____

☐ DENIED FAMIS COVERAGE

FOR: _____

REASON: _____

MANUAL REFERENCE: _____

☐ ACTION WAS NOT TAKEN ON YOUR MEDICAID APPLICATION DATED: _____ WITHIN

_____ 10 DAYS FOR A PREGNANT WOMAN OR _____ 45 DAYS (90 DAYS FOR DISABILITY DETERMINATION).

REASON: _____

☐ YOU WILL RECEIVE A NEW CARD BECAUSE THE FOLLOWING PEOPLE ARE NOW ELIGIBLE: _____

☐ OTHER: _____

IF YOU DISAGREE WITH THE ACTION TAKEN, YOU MAY HAVE THE RIGHT TO FILE AN APPEAL. INFORMATION ON THE BACK OF THIS FORM EXPLAINS YOUR RIGHT TO APPEAL AND HOW TO ASK FOR A FAIR HEARING.

_____	_____	_____	_____
(DATE MAILED)	(WORKER'S NAME)	(TITLE)	(PHONE #)

APPEALS AND FAIR HEARINGS

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. EXCEPTION: Family Access to Medical Insurance Security Plan (FAMIS) is not an entitlement program. Therefore, denial of assistance for a child or ineligibility for additional benefits for a child who has been found eligible when funding is not sufficient is not appealable. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you desire free legal advice, you may contact your local legal aid office.

A fair hearing provides you the opportunity to review the way a local social services agency has handled your situation concerning your stated need for Medicaid or FAMIS. The fair hearing is a private, informal meeting at the local social services agency with you and anyone you wish to bring as a witness or to help you tell your story, such as a lawyer. The person who conducts the hearing is someone from the Department of Medical Assistance Services, not someone from your local social services agency. The hearings officer makes a decision on your appeal.

If you wish to request a hearing, the request must be made within 30 days of receipt of this notice to the Department of Medical Assistance Services. The form to request a hearing may be obtained from the local agency or the Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

You will be notified of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call the hearings officer immediately. You may bring a representative and/or witnesses to the hearing to help you tell your story. Your eligibility worker, a local agency supervisor, and possibly other agency staff who know about your case may also be at the hearing to tell how the agency's decision was reached.

At the hearing, you and/or your representative will be given the opportunity to:

(1) examine all documents and records, which are used at the hearing;

(2) present your case or have it presented by a lawyer or by another authorized representative;

(3) bring witnesses;

(4) establish pertinent facts and advance arguments; and

(5) question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

The decision or recommendation of the hearings officer shall be based exclusively on evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In such an event, you and the local social services agency would be given the opportunity to question or refute this additional information.

You will be notified in writing of the hearings officer's decision on your appeal within 90 days of the date your appeal request is received by the Department of Medical Assistance Services.